EDUCATION AND HEALTH STANDING COMMITTEE

INQUIRY INTO ABORIGINAL YOUTH SUICIDES

TRANSCRIPT OF EVIDENCE
TAKEN AT PERTH
MONDAY, 12 SEPTEMBER 2016

SESSION THREE

Members

Dr G.G. Jacobs (Chair)
Ms R. Saffioti (Deputy Chair)
Mr R.F. Johnson
Ms J.M. Freeman
Mr M.J. Cowper
Ms J. Farrer (co-opted member)

Hearing commenced at 11.58 am

Professor SVEN SILBURN
Clinical Psychologist and Researcher, Menzies School of Health Research, examined:

Professor JONATHAN CARAPETIS
Director, Telethon Kids Institute, examined:

Mr GLENN PEARSON
Head of Aboriginal Health Research, Telethon Kids Institute, examined:

Professor DAVID LAWRENCE
Researcher, Telethon Kids Institute, examined:

The CHAIR: Thank you very much, gents, for appearing before us today. On behalf of the Education and Health Standing Committee, I would like to thank you for your appearance. The purpose of this hearing is to discuss our inquiry into Aboriginal youth suicide. Let me begin by acknowledging the traditional owners of this land and expressing my gratitude that we are able to meet here today. I would also like to pay my respects to the local elders past and present. I am Graham Jacobs, the chair of the committee. On my left is Janine Freeman. On her left is Rob Johnson and on his left, Murray Cowper. On my right are Alison Sharpe and Catie Parsons, the executive who support us in this inquiry. We have Hansard to record this for the public record—thank you for that. This committee is a committee of the Legislative Assembly. The hearing is a formal procedure of Parliament, but I hope it is not too formal. It does command the same respect given to the proceedings of the house. Even though we are not asking you to give evidence on oath or affirmation, it is important that you understand that any deliberate misleading of the committee may be regarded as a contempt of Parliament. If you quote any documents during your evidence, it would assist Hansard if you could provide the full title for the record.

Before we commence, gentlemen, I have to ask you some questions. I am sorry about these. Have you each completed the "Details of Witness" form?

The Witnesses: Yes.

The CHAIR: Sorry about this: do you understand the notes at the bottom of the form about giving evidence to the committee?

The Witnesses: Yes.

The CHAIR: Did you each receive and read an information for witnesses sheet provided with the "Details of Witness" form today?

The Witnesses: Yes.

The CHAIR: Would you please state your full name and the capacity in which you appear before the committee? I do not know whether Professor Carapetis or someone would like to give a bit of an overview or summary before we start the question and answer time. Maybe we can start with Sven and move through just on who you are and the capacity in which you appear before us today.

Prof. Silburn: I am Sven Silburn. I am a professor at the Menzies School of Health Research. Prior to moving to that position in Darwin, I was at the Telethon Institute. I was also the chair of the Western Australian Ministerial Council for Suicide Prevention for 10 years. I was one of the authors of the national Aboriginal and Torres Strait Islander suicide prevention strategy.

Ms J.M. FREEMAN: When did you shift to Menzies?

Prof. Silburn: It was 2009.

Prof. Lawrence: I am David Lawrence, a research professor at Telethon Kids Institute. I have been involved in a range of research projects, including the Western Australian Aboriginal Child Health Survey and "Young Minds Matter", the Australian Child and Adolescent Survey of Mental Health and Wellbeing. We are also currently working on a Mental Health Commission–funded project to re-establish the WA coronial suicide information system.

Ms J.M. FREEMAN: Sorry, is that to get the coroner to measure if someone has committed suicide? Is that put in the coroner's report or in the statistics?

Prof. Lawrence: The state maintained a database of all suicides in Western Australia from 1986 onwards but that lapsed in around 2010. We currently have a contract to re-establish that, so we are going through all the suicides that occurred from 2009 to 2014. The purpose of the database is twofold—to support postvention activities with the Mental Health Commission and the Coroner's Court, but also to provide a research evidence base to try and understand the antecedent factors that precede suicide and to look for gaps in terms of access to services and issues such as that.

Ms J.M. FREEMAN: Are you doing that through looking at the death certificates or the coroner's report?

Prof. Lawrence: And all the aspects of the investigation—the police reports, witness statements and autopsy reports et cetera.

Ms J.M. FREEMAN: They were kept until 2010?

Mr R.F. JOHNSON: Why did it lapse in 2010?

Prof. Lawrence: I think it was one of the things that just sort of went missing when the Ministerial Council for Suicide Prevention contracts, to support a range of her work, were let to a different agency. The Telethon Kids Institute had been maintaining that up to that point and in the transition to the new provider, the database seems to have just lapsed, unfortunately.

Mr R.F. JOHNSON: I would like to come back later and investigate why it lapsed in more detail, if I may.

Prof. Carapetis: I am Professor Jonathan Carapetis. I am the director of the Telethon Kids Institute. I also hold appointments at the University of Western Australia and Princess Margaret Hospital for Children. Up until 2012, I was the director of the Menzies School of Health Research, where Sven is based. I have had a long history of involvement in Aboriginal health and wellbeing research. My background is not specific to this inquiry; it is more about infectious diseases but, as director of two leading research institutes involved particularly in Aboriginal health, I have developed a broad set of interests around wellbeing. I offer myself as both a leader of an institute that has a great history and a great interest in this area, but also my expertise that relates to the taking of evidence and putting it into practice in Aboriginal health and wellbeing.

Mr Pearson: Good morning. My name is Glenn Pearson. I am currently the head of Aboriginal health research at the Telethon Kids Institute. I have been there for almost 12 years. I spent 14 years in the state and commonwealth and working almost 10 years in the Department for Child Protection, for a period of time in the state health, and then in the latter part in ATSIC, working with Mick Gooda at the WA state policy office. My background is also in teaching and for the 12 years I have been in the institute, I have been involved in a whole range of projects. The needs of Aboriginal kids and families are one of the four priority areas for the institute. Indeed, of the issues that are here today, one of them touched me personally. Similarly, I am also on the state ministerial suicide prevention council at present.

Prof. Carapetis: Chair, may I make a brief opening statement?

The CHAIR: Go ahead.

Prof. Carapetis: On behalf of all of us here, but I also just reiterate that this is actually a joint submission we have made between Telethon Kids Institute and Menzies School of Health Research. I think that is one of the strengths, that really you have got probably the two leading research institutes in this area, I would suggest, in the country. The key points that we have tried to make in our submission—I suppose in a lead-in to that, I will point out that, last week I was up in Broome for a workshop that we co-hosted with the Kimberley Aboriginal Medical Services. Telethon Kids has an office in Broome. It has a vision to join with local partners on a much broader program of research that will be of use to the Kimberley. We convened a workshop—KAMS actually convened this workshop—to try and set child and family health research priorities for the Kimberley. It was just a fabulous experience. It was a day and a half. We had the full KAMS board there. We had representation from the health sector and other sectors, and a great deal of buy-in from all who participated. There is a huge enthusiasm to bring evidence to what happens to improve the lives of children and families in the Kimberley. What I can say is that the topics of youth suicide, as you can imagine, came out pretty much top of the list in terms of their priorities. Out of that were a lot of other concerns they have around family function and community function, drugs and alcohol and the like. There is a real feeling that not only is this such a major issue, particularly for the Kimberley, and that we need to take a much more concerted effort, but that the time is right because there is a sense of cohesion in the Kimberley that I have not seen pretty much anywhere else in Australia. I think it is very timely for us to be able to present at this meeting.

The points that we would like to make is, one, about the importance of good data. I think we should come back to the coronial database, as we talked about. We have been working on re-establishing that coroner's suicide database to underpin the work of the Mental Health Commissioner's state suicide prevention strategy. A suicide prevention data task force has been established out of that. The idea is that whatever we do, we need to have it informed by the best quality data about what happens to young people who suicide. Indeed, we believe it should be expanded to the whole area of self-harm. That would be critical, but also to be able to evaluate what we are doing—to be able to set a mechanism to ensure that we can track this well. We have not done this well enough in the past. David Lawrence can talk to this. We are happy to come back to it.

Prevention is obviously critical. We know that suicide is the endpoint of great distress. We also know that the vast majority of people who undergo that sort of stress and distress do not end up committing suicide but a much higher proportion of young Aboriginal people either commit suicide or attempt self-harm. To try and address the circumstances that lead to that are crucial, which requires a focus on improving the mental health and wellbeing of Aboriginal children and young people, I would say everywhere, but there has to be a particular focus on remote areas because the rates seem to be extraordinary in those areas. We need to be looking at community and family function as key predictors of mental health outcomes. Both Menzies and Telethon Kids Institute have undertaken extensive research into the mental health and wellbeing of Aboriginal children and families.

[12.10 pm]

We need to understand what has worked. There are some examples of things that have worked. We would like to, if we can, come back to the particular experiences in some Northern Territory areas, especially the Tiwi Islands, when I was living in the Northern Territory during the 1990s. The spate of suicides was extraordinary on the Tiwi Islands and that has been arrested. There are some thoughts about how that might have been arrested and how that might relate to some particular parenting programs. Sven Silburn will talk about that. We need to learn about what has worked. We also need to understand that, whilst there has been important focus that is needed on broad strengthening of communities and families, there are particular subgroups of young people who are at extremely high risk. They might have identified in various ways—through self-harm, through other indicators, through domestic violence et cetera. Especially when they have presented for care, have we got a sufficient approach to make sure that there is a follow-up? The risk of

suicide in the period shortly after a self-harm incident is quite dramatic. We need to make sure that we have got our care systems working well.

The third point I would like to make is that intergenerational trauma needs to be recognised as perpetuating the cycle of disadvantage and poor outcomes for Aboriginal people. We know that this adds enormous levels of complexity to what one does about it, but one has to take a whole life course approach. We know that what happens for a young person affects what happens to them as they get older, and then what happens to an individual is then passed on to the next generation. If we are going to deal with this, we have to take a long-term view. Again, this is something that both Menzies and Telethon Kids Institute have had a long association with. We need to focus on healing and recovery. It is important to acknowledge the role of communities and that communities are really, we saw this in the Kimberley, trying to step up and bring culture and bring family into the healing process. We need to empower that process as much as possible. Last week when I was talking to the team about what we should be saying to you, I was trying to put myself in your shoes and thinking that what you would like is some practical strategies in addition to the broader —

Mr R.F. JOHNSON: Yes, please.

Ms J.M. FREEMAN: If you could fix it, that would be very good.

Prof. Carapetis: We are here to help. We came up with a few that may be of interest to you. The data issue is one that I think is a very practical strategy—supporting the re-establishment of the coroner's suicide database to provide that reliable evidence, to recommend that we change the ways in which Aboriginal suicides are investigated to include some more culturally appropriate, less legalistic inquiry methods, with a focus on prevention, not just determining the cause of death. We can come back to that suggestion and David can speak to that. We would like to recommend that parenting programs be looked at in places where they seem to have worked, such as the Let's Start program on the Tiwi Islands. This could be implemented, particularly in remote settings, and evaluated appropriately. There are some models and we would be very happy to talk to that. Sven, in particular, can talk to that.

In the Northern Territory there has been a recently developed system for people discharged from hospital after a suicide attempt. It is called the NT enhanced hospital discharge support program. It implements much better follow-up after discharge, and longer term surveillance and support when discharged from hospital. It resulted directly from work that happened at the Menzies School of Health Research funded by beyondblue. We believe that there is a significant gap in the capacity in Western Australia to follow up individuals who have presented after an attempted suicide, which is the greatest period of risk.

Mr R.F. JOHNSON: Who does the follow-up in the Northern Territory?

Prof. Silburn: It is a project that is funded by beyondblue. The people who have got the contract are Anglicare, but it is jointly funded by NT Health. Essentially, in the Royal Darwin Hospital emergency department, every case of a young person who presents for suicide-related admission, they are linked up with a support person who does a lot of work before that person is discharged back to their community. It usually involves working out—they might come from a very small community where there are no professionals but there are some strong people in the community. There are people that can be charged with taking some sort of responsibility to see that someone keeps an eye on this person—here is what this person is going to need to get back on their feet—and to see that if there is a follow-up doctor's visit, that that person gets to their appointment and that they follow up on their care. The reason for doing that is when we looked at two years of admissions to Royal Darwin Hospital and Alice Springs Hospital, we could see that the peak period for re-attempt or completed suicide was between one and three months following that admission. There has been a big increase in the number of people coming into hospital. In a sense, that is a bit of an artefact and it may in fact be a good thing, because people in communities, when a young person is talking about suicide or has made an attempt, they medevac them into hospital almost

immediately. You are getting many more people referred at an earlier stage. That program is being evaluated; at this stage, it falls into the category of showing good promise and it is certainly reassuring to the communities who have to look after someone once they are discharged from hospital.

Mr R.F. JOHNSON: How long has the program been in place in the Northern Territory?

Prof. Silburn: This is now its second year.

Mr R.F. JOHNSON: Would it be your view that we should have the same program working in WA?

Prof. Silburn: I think there is something that is happening in the metropolitan areas of WA, but it is the remote areas where that falls down. I think that the Aboriginal mental health service has always played a role in doing that, but it is a question of how you link people up. For metropolitan people in, say, the Perth area, when we did the national consultations for the national strategy, one of the very strong recommendations—we had about 60 Aboriginal people who came to that from different agencies—their concern was that when there is a suicide attempt, two things are of concern to Aboriginal people. One is that it is much less likely that the family will be interviewed by the clinicians. They tend to do most of the work with the young person themselves. That largely seems to be because the clinicians are not confident in working with people from a more traditional background. The advice they gave was that mainstream services could do a much better job of referring to Aboriginal counselling services or an Aboriginal health service because they are much better equipped to deal with multi-problem families because it is their daily custom; whereas, if you are in a mainstream service, if you have a multi-problem family crop up and suicide is the presenting problem, when you start to go into it, there are myriad other problems that need to be looked at. They thought that if you got a better connection between hospital and other clinic services with the Aboriginal counselling services, that could be very advantageous in getting a better outcome.

Mr R.F. JOHNSON: In a nutshell, we really need more of that facility in the remote areas—in the remote villages.

Prof. Silburn: Yes.

Prof. Carapetis: I think it is also needed urban, I think Sven is right. It is my understanding that there has been, particularly, focus in the acute care settings and improving that quality of service. My understanding is, though, that as soon as that individual is then sent out of the acute care—when they are discharged from the emergency department—the follow-up is perhaps not as intensive as it could be. My understanding is that in the remote areas it is close to zero or non-existent. Would that be correct?

Ms J.M. FREEMAN: You have put in your submission about the involvement of Aboriginal people in these sort of programs. Given that it is contracted to Anglicare, what I got from what you are saying is that Anglicare goes into those communities and identifies someone who can be like a carer or assist them. Is the actual program run by Aboriginal people from Anglicare, or is it still non-Indigenous people going in, getting paid and talking to nonpaid people in the community saying, “Keep an eye out for that person”?

Prof. Silburn: The program is managed by Anglicare. They employ some Aboriginal and some non-Aboriginal social workers who do that job. They are basically on call to the hospital.

Ms J.M. FREEMAN: So it goes beyondblue, Anglicare, down. There is a lot of admin money that might well get lost in the translation, but anyway.

[12.20 pm]

Prof. Silburn: The point is that this is a sort of demonstration project. It is trying to establish: is there a better way to do things? There is evidence that early assertive intervention can really make a difference.

Ms J.M. FREEMAN: There is no doubt about that. We have had lots of evidence about postvention. Postvention for suicide is very important in terms of that.

The CHAIR: After the acute intervention in an acute hospital, what would be the role of transitional accommodation—I know we cannot have one in every remote setting—in a major regional centre before they step down again into the community? Often the issue is they get over their acute phase and they are basically told they can go home, but, as you have said, there is not much support at home.

Prof. Silburn: That in fact is one of the other very strong recommendations around the country. We did consultations in every state and territory, and that was a recommendation that came up virtually everywhere. I agree that often these people are quite needy when they leave hospital, and telling them to go straight back to their community can be quite disruptive to their community, so having some step-down is highly advantageous.

Ms J.M. FREEMAN: We also heard evidence, when we spoke to the hospital in Kununurra, from one of the emergency doctors that there were other factors involved. There had not been the suicide ideation beforehand. It had been an —

The CHAIR: Impulsive.

Ms J.M. FREEMAN: Thank you—it has been an impulsive decision, and alcohol was involved in that. So when you are talking about this sort of aspect, it takes in those broader social aspects of things, not just a mental health analysis but a wellbeing analysis. Is that what you are saying?

Prof. Silburn: Exactly.

Prof. Carapetis: I guess we are still saying that within that, yes, but it is probably more complex in Aboriginal communities than perhaps in non-Aboriginal communities. There is still the concept of identifying the highest risk and being able to get a focus on them.

Ms J.M. FREEMAN: Yes—he was talking about Aboriginal communities.

The CHAIR: Can I ask you about an issue that we have talked about before today with other groups around the sort of clinical, if you will excuse me, western model of clinical depression leading to suicide, where that sort of clinical model does not fit with Aboriginal youth suicide and the Aboriginal youth suicide space, excuse the expression again, where a lot of Aboriginal youth are surrendering their lives, and that clinical model is in fact counterproductive in making a difference, because we could be barking up the wrong tree?

Prof. Carapetis: So the concept as to whether or not there might be other more cultural factors?

Ms J.M. FREEMAN: We had someone come in who worked in this space and who said that Aboriginal suicide and non-Aboriginal suicide are different—that 80 per cent of non-Aboriginal suicide is related to depression, and it is not the same in Aboriginal youth suicide but is much more impulsive, and it is culturally different. That is what we have told. So, when we apply mainstream across, we are losing some important factors.

The CHAIR: And the question was whether some of that was culturally bound and not just the pure clinical depression that we deal with in perhaps western society.

Prof. Silburn: I think it is certainly true in the western model and in non-Aboriginal communities that depression is one of the most easily identifiable risk factors and it is clearly present in the majority of cases. It is much more difficult to diagnose in the Aboriginal context when all these other cultural factors come into play. It also does not recognise that while many of the risk factors are the same, what you see in highly disadvantaged communities is many more of the risk factors

being present during the course of a person's life, and that the end points where the impulsivity comes out, and where it may be fuelled by alcohol, results in something apparently coming out of the blue. When go to the coroner's records and look as where you have got a good life history of that person, what you invariably see is that there is a long-term history of traumatic exposures. The Ombudsman's report in WA found that about two-thirds of Aboriginal suicide deaths under the age of 18 had had contact with the child protection service at some stage, and that the self-regulation that develops with early brain development in the first two to three years of life, that is where one of the great opportunities for intervention is that will have a benefit in terms of resilience and a lesser likelihood of all these other adversity factors leading to that drastic outcome.

Ms J.M. FREEMAN: Is that that idea of attachment?

Prof. Silburn: There is good evidence about that. The World Health Organization and UNICEF are actually running programs in refugee camps where you have got highly traumatised mothers looking after small children. Where you are in a highly traumatised situation exposed to multiple stresses, that has a major disrupting effect on early attachment. In the Aboriginal community you have got very high rates of antenatal depression and you have got very high rates of postnatal depression—extreme—and the children of those mothers are much more likely to become at risk of involvement with the child protection system and subsequently to get into all sorts of issues with self-regulation later in life. So the World Health Organization has developed a program called Care for Child Development. They are looking at trialling that in the Kimberley, I believe. The previous Northern Territory government was going to roll that out to every worker who had face-to-face contact with families as a way to build early attachment and understanding of what the developmental needs were of children in the first two to three years. The evaluation of that program in a number of countries now, including on a very large-scale in places like Pakistan and South America, has shown very beneficial outcomes not just for mental health issues but much better outcomes in terms of school attendance and achievement and just having a better start in life generally.

Ms J.M. FREEMAN: Who runs that? So Care for Child Development is run by the UN?

Prof. Silburn: No. It is World Health Organization and UNICEF.

Ms J.M. FREEMAN: So will UNICEF deliver it in Western Australia or will the state government deliver it? What is the expectation?

Prof. Silburn: Certainly I know that with the plans for the Kimberly in terms of their early child initiative, it is one of the programs that they are talking about implementing, and the developer of the program is coming out to the Kimberley to help train up a local bunch of implementers to deliver that program.

Ms J.M. FREEMAN: Who is the developer of the program?

Prof. Silburn: Her name is Professor Jane Lucas. Something like 20 countries are now implementing it. It is particularly designed to be delivered by the equivalent of Aboriginal health workers, and it is done in a very conversational style that is very supportive. It does not appear to be clinical, but it is based on very good evidence, and it is a subtle and effective program.

Ms J.M. FREEMAN: I am still confused as to who in Western Australia is intending on funding or making this happen in the Kimberley. Is that the health department or is that —

[12.30 pm]

Prof. Silburn: It is through Telethon and the BHP initiative in the Kimberley.

Mr Pearson: The BHP initiative is actually in the Pilbara.

Prof. Silburn: Sorry, the Pilbara.

Ms J.M. FREEMAN: It is in the Pilbara.

Prof. Silburn: That is right.

Prof. Carapetis: Our Pilbara initiatives are foetal alcohol spectrum disorder.

Ms J.M. FREEMAN: This is to do with foetal alcohol spectrum disorder?

Prof. Carapetis: Yes. I do not know if the care for children is part of that; I have not heard that it is, so we will have to come back to you on that.

Ms J.M. FREEMAN: Yes, if you could come back to me on that. I just want to finish and then I will pass over. Everything we have heard about child development is really important. Again, I have to come back to a question, which is: that sounds like great program, but how do you ensure that you meet what you have also said in your submission, which is the involvement of Aboriginal people or the ownership by Aboriginal people of the program that they actually develop? This, again, is taking a program which clearly has got really good outcomes, but how do you ensure that these things actually reflect on-the-ground ownership development and that whole thing about the communities themselves? We have heard often that the communities themselves actually know the solutions; we are just not giving them the tools to be able to deliver those solutions. How do you do that?

Prof. Carapetis: Perhaps I could just make an opening comment around that, which is that I think what you are asking is a critical question and it goes to the fact that: are we going to find a program that is going to solve things? It is not going to be a program. This is why in my introductory comments I mentioned the Kimberley, because I think there is an opportunity now to take a much more comprehensive approach, for example, to make youth suicide history in the Kimberley because there is such enormous buy-in in that region, not just from community representatives and organisations, but from external organisations like ours. So I think there is an opportunity that would also allow that co-design concept of how you can work up individual programs or adapt them locally. I know Sven can talk to one or two of those, but, Glenn, I might give you an opportunity to talk to this.

Mr Pearson: Yes. I go back to the comment around: is there a place for western-based responses? Yes, there is. These are highly complex issues with a diverse range of needs. It really goes down to—a lot of it is around the practitioner. I think you touched on workforce development. That is quite a critical piece of the puzzle in the sector itself and about people being trained and then developed to be able to respond to those complex needs and still bring forward those sorts of capacities that engage, so there is a place because of a diverse range of needs. Jonathan's point around the co-design is absolutely critical around these things. These organisations that work out of Canberra—that is pretty much every other Aboriginal guy—and those in Canberra are very adept at taking either Perth-centric or Canberra-centric programs and ideas and then they will adapt them to fit perfectly, or as best they can, for the communities to develop with the resources they have, and they do that very well. They are at capacity to be able to do it. The frustration with that, though, is continually having to hold it at two different levels in order to respond to their community's needs, so in terms of those reporting requirements, based around getting on with responding to their community's needs, that is what they do. So there is some sophistication capacity that is already inherent in that space, whatever new initiatives that have been proposed need to, as they go forward, because these are their kids, after all, start with them in a conversation around: how does this fit in? What do we need to do? What is really important in all of this is the issue of data and evidence. What happens in the actual spaces, as it does in a lot of other places, there is a lot of speculation based on not very good data, and I want to reiterate that. I think that sounds ironic, from an Aboriginal person, but I really do believe that. We are doing a complementary piece for the royal commission at the moment and the amount of data that is not available, and the quality of that data, that could help make good decisions, is not there. It means that somewhere, someone is going to have to take a best guess, and I think we owe it a bit more than that.

The CHAIR: Sven, do you want to talk a bit about Let's Start, for example?

Prof. Silburn: Jonathan mentioned the Tiwi Islands suicide cluster where, in the space of two years, they had, I think, close on 20 suicides. The Tiwi Islands have a very small population and the Tiwi Islands board's response to that—which is an Aboriginal-controlled health board—was that they got all the elders together, they had community meetings and basically their decision was that they felt that children were not being given proper guidance in their families from early on and that they had to do something about improving parenting. The Tiwi Islands Board then commissioned Gary Robinson, who was then at Charles Darwin University, and he worked with the local Tiwi people to adapt a parenting program, based on the principles of a program developed in Victoria but adapted for delivery in that context, so it is not just a group family training program; it involved a 12-week program where a parent or an aunty or grandparent or whoever was responsible for the kid, and sometimes three or four family members, would come along, and it was both a parent and a child group session done in a very culturally appropriate way. For example, every session began with singing and a joint parent and child session. Then the kids went off and had a social skills–type group while the parents looked at parenting issues and the challenges that they face, but also learning some common principles that work in helping kids to be able to give clear instructions so that the kid knows what is expected, how to deal with complex situations that arise without the conflict escalating, how to discipline without hurting the child—a whole range of things like that that are common to most cultures, but it was implemented in a very culturally traditional way. That program is the only evidence-based Indigenous parenting program in Australia. It has had very good outcomes in terms of the difference that it makes to kids' transition into school. It is designed for parents and children aged three to five, but the outcome of that is that that program is now continuing, and has continued in a very well sustained and supported way on the Tiwi Islands, and the Northern Territory government and the Australian government are busy rolling it out to several other communities across the Top End. It is an example of a community-initiated and developed program, working with the best traditional knowledge and the best western scientific knowledge to come up with a really well documented and evidence-based program that can be supported and that government is happy to continue supporting. But the interesting outcome of that is the way in which the suicide cluster abated and that there was a long period where there were no suicides and that the rate of suicide attempts dropped dramatically.

Ms J.M. FREEMAN: Have they remained dropped?

Prof. Silburn: Yes.

Ms J.M. FREEMAN: What interests me is that you are saying that it started up as an example of a community-initiated program, and then they had someone come in, and then they developed it, and then they delivered it, and then they got the outcome. Now we are going to take this model and we are going to take it into other places across the Top End. Will it do that first process of a community-initiated program in the first instance—you are going to the community, saying, "This is what we want to deliver, but let's sit down and work out how you deliver it. Singing may not be your thing, but dancing may be your thing"?

Prof. Silburn: Largely it has come in on the basis of community request, and it is a request usually from the strong women and the elders in the community. They have heard about the results elsewhere and they want their community to have something like that too.

Prof. Carapetis: It is a critical step. A parallel analogy that I give is the foetal alcohol spectrum disorder work that we are involved in as a partnership with Fitzroy Valley, and have been for many years, with June Oscar and her team. Those learnings are now being taken elsewhere, and we have a big initiative in the Pilbara and in other communities in the Kimberley, but the research is very clear that that first step of community engagement and community leadership is critical. You cannot go in and say, "Here it is"; you have to get that first step happening, and you will not have any trouble with that buy-in around youth suicide; it is the number one issue as far as most people are concerned.

The CHAIR: Rob, would you like to ask about the data?

Mr R.F. JOHNSON: Yes; I am glad you did not forget that, Mr Chairman. I just want to know a bit more about why the system for collecting the data lapsed in 2010, I think you said. To go forward, you need some history, and you need that data. It is essential, in my personal view, to be able to frame actions, policies and various things that you need to put in place to be able to combat and deal with this crucial issue of our young Aboriginal people committing suicide; I think is essential. I am just wondering who is responsible for letting it lapse?

[12.40 pm]

Prof. Lawrence: Telethon Kids had a contract to support the work of the Ministerial Council for Suicide Prevention for a significant period of time. As part of that we had been maintaining the database of suicides in Western Australia: The contract was passed to a private provider in 2010. It was not just a contract for the maintenance of the database, but I guess the contract was around work to deliver suicide prevention programs, which I think there have been changes in the make-up of the ministerial council at that time and people were interested in trying some new ideas in that space. Unfortunately, there seemed to be a case —

Mr R.F. JOHNSON: Was this a government minister's decision at the end of the day or was it Telethon Kids' decision?

Prof. Lawrence: No, it was not the institute's decision to withdraw from that.

Mr R.F. JOHNSON: No, I cannot imagine it would be.

Prof. Carapetis: We wanted to make that list.

Mr R.F. JOHNSON: So it was a government minister's decision to defund it, if you like?

Ms J.M. FREEMAN: Or contract it out.

Mr R.F. JOHNSON: Or contract it out to somebody else.

Prof. Lawrence: Yes, pass the contract to somebody else; that is correct.

Mr R.F. JOHNSON: That was in 2010?

Mr Pearson: Yes; we were not successful in the contract.

Prof. Carapetis: I was not there. Was this because, as you said, there was a decision to articulate not only the data side of things, but provision of a service? Am I correct that there was a perception that we were not in the right position to undertake the service provision aspect of this?

Prof. Lawrence: Yes.

Mr R.F. JOHNSON: Was that from the ministerial council of mental health ministers or was that simply the decision of the Western Australian mental health minister?

Mr Pearson: It was.

The CHAIR: No; I missed out. You cannot blame me.

Mr R.F. JOHNSON: It was not Graham. I think you will find it was the one that followed you, I think you will find.

Prof. Lawrence: I believe it was the decision of the ministerial council, but I presume that that would be referred to the minister.

Mr R.F. JOHNSON: Yes. At the end of the day, what happens in WA is down to the WA minister, obviously. So, because of that decision by the WA minister, that service of collecting all that essential data, if I might say that, has been lost for that period of time, or are they recovering that information now?

Prof. Lawrence: We are in the process of putting that data back together. It will be possible to reconstruct the database, but obviously there has been a period of time when we have not —

Mr R.F. JOHNSON: We are now six years from when that happened.

Prof. Lawrence: Yes, absolutely.

Mr R.F. JOHNSON: Trying to retrieve that essential data of six years—and you are not finished yet, I am sure.

Prof. Lawrence: No; it is a work in progress.

Mr R.F. JOHNSON: And it could be another year or two to actually finalise collecting all that data.

Prof. Lawrence: We are hoping to have the database up to date by the middle of next year, all being well.

Ms J.M. FREEMAN: Is that only kids or is it adults?

Prof. Lawrence: No, no; this is children and adults.

The CHAIR: It is the suicide statistics across the board.

Prof. Lawrence: Yes.

Mr R.F. JOHNSON: I am sorry; I am not cross-examining you. I am just flabbergasted that any Minister for Mental Health would take that sort of action and that sort of decision on such an imperatively important issue.

Prof. Lawrence: Yes. Well, I was not the person who made the decision, but I would be certain that at the time the decision was made, the decision was not made thinking we do not want this data any more. I am sure the service was let to a different provider with the intention that it would be picked up by someone else, and somehow that has been fallen through the gaps. I am assuming that that is an unfortunate side effect of what has happened rather than a deliberate strategy not to have the data. But, in any event, we do have that gap and we are in the process of putting that data back together.

Mr R.F. JOHNSON: Thank you very much for that very honest answer.

The CHAIR: Can I ask: in the work that is done in interrogating that data, if you like, or looking at it, can you give us some idea around—in suicide within Aboriginal youth—I do not want to use the word "causative", but maybe predisposing factors in some of that data history in Aboriginal youth suicide, because, for us, and for me particularly, I was looking at some of those predisposing issues. We talk about social disadvantage. Obviously, that can lead to hopelessness and helplessness and that can lead to suicide. Can you just tell us a bit about some of the predisposing, causative issues around some of those statistics in Aboriginal youth suicide in the work that you have done?

Prof. Lawrence: Absolutely. So, from the data that we have, and we have data going back to 1986, there is no one path to suicide; there are a range of different life circumstances that can result in someone taking the decision to end their life. We do know that Aboriginal people are overrepresented in suicides. About twice as many Aboriginal people have taken their life compared to what you would expect based on the rest of the population rates. We also know that younger Aboriginal people are more likely to take their life than younger non-Aboriginal people. So, amongst younger age groups, the difference is even higher. As you say, there are socioeconomic gradings. People who live in the bottom 20 per cent of the index of socioeconomic disadvantage are more likely to take their life. In both non-Aboriginal and Aboriginal people, mental illness and substance abuse are the two most prevalent risk factors that lead to someone taking their life. That is probably less in the younger people, so amongst people aged 20 and over, the majority of suicides are amongst people who have mental health problems and who have sought treatment for mental health problems. In adolescents in both non-Aboriginal and Aboriginal people, there are less people

who have at least had a diagnosed mental health problem or who have sought treatment, and there are different circumstances, I think, that lead particularly young people to end up taking their life. Certainly, though, however, substance abuse is a big factor. We know about 25 per cent of people who complete suicide have had a previous hospitalisation for an attempted suicide. So programs that are based around following up people who have attempted suicide are targeting an important group, but not all people who suicide have attempted suicide in the past. There certainly are some people who take their life when family and friends and service providers have no advance warning that that is going to happen, so that idea of an impulsive suicide or perhaps a suicide that is not readily apparent why that is the case.

One issue that I did want to raise with the committee is that while we have been putting the database back together, we noted that the coroner is assisted by the police coronial investigations unit investigating suicides in the metropolitan area. In regional areas, district magistrates also have a coronial role, and police in regional areas also have a role in investigating suicides that occur in those areas. There does seem to be a difference in the detail and the quality of some of the investigation work between some of the more regional and remote suicides and the suicides that occur in the city. I particularly notice that with some of the Aboriginal deaths that have occurred in the remote communities—this is not the case in all deaths, but there are some deaths where you can read the entire file of all the investigation and come away thinking, "I know what happened on the day of or the day prior to the death in a lot of detail, but I really have no sense of what happened in the lead-up to that and what were the circumstances of the person's life." I have a sense that because the police investigations are done in quite a formal way and the notes are written up in the form of a signed witness statement, there could be an issue with some people feeling uncomfortable with that sort of inquiry being conducted in that way. In Victoria, the State Coroner has a legislative role in suicide prevention as well as the important role of determining whether a death is a suicide or by some other means. Obviously, police and the coroner have an important role to determine the cause of death, but once a suicide has been determined that it was a suicide, from a suicide prevention point of view, I think there is a case to be made that it does not necessarily have to be investigated from a legalistic point of view and signed witness statements and statements on oath et cetera; there is potentially a role for investigation around understanding the circumstance of a person's life that may be better played by someone who is outside the police system or someone who has more of a stronger relationship with the community, and perhaps Aboriginal people themselves would be better placed to undertake some aspects of that investigation to provide better information about what it is that is actually underpinning the life circumstances in the bigger period before the actual act of suicide occurs. From a suicide prevention point of view, obviously, if someone is in a very distressed state, you want to act straightaway, but you also want to be able to look back before that and say, "Well, what are antecedent opportunities where there may have been contacts with services, contacts with Child Protection, issues that have come up within the school system et cetera where perhaps there was an opportunity to do more than what was actually done?"

[12.50 pm]

Mr R.F. JOHNSON: Who, in your view, should oversee that action coming to fruition and happening? I can appreciate the benefits of that, but unless you appoint somebody to actually give them the job and say, "This is what needs to be done. We want you to talk to the relevant people within the Aboriginal communities to be able to garner that information so it will help us in the future in relation to preventing suicide"—who should oversee that?

Prof. Lawrence: I do not have a specific model in mind. I think that the coroner could still have a role in collecting information relevant to suicide prevention, but I think it is something that would probably be best developed in collaboration with Aboriginal communities to say, "Well, what would be the best way of investigating the circumstances underpinning these deaths?"

Ms J.M. FREEMAN: You said in Victoria the State Coroner has a legislative role in suicide prevention.

Prof. Lawrence: Yes.

Ms J.M. FREEMAN: I am assuming that is juxtaposed to the fact that the State Coroner in Western Australia does not have that role. I should probably know exactly what role the coroner has —

Prof. Lawrence: It is not specifically built into the legislation. I am sure that all coroners do take suicide prevention as an important part of what they do.

Ms J.M. FREEMAN: In Victoria, do they take a more active role in looking at that investigative role around health and wellbeing and social circumstances and various other factors instead of that legalistic role because of this particular aspect of it?

Prof. Lawrence: My sense is that yes, they do have some funding that is specifically dedicated to suicide prevention activities that are probably larger than the role that we see in Western Australia and other states.

Prof. Silburn: The Victorian coroner has always had much more of a reforming role as part of their duty statement and they do have funding to commission particular inquiries about particular causes of death with a view to preventing future deaths, rather than determining what was the—so they make very strong proactive recommendations, much more so than other coroners.

Mr M.J. COWPER: I have some difficulty with some of the comments you have made. One, have you ever investigated a sudden death of a person?

Ms J.M. FREEMAN: He is an ex–police officer—ex-copper from the Kimberley.

Prof. Lawrence: I absolutely understand that it is a very, very difficult role. I find even just reading the stories quite difficult.

Mr M.J. COWPER: When a police officer attends a sudden death, they do not preconceive that it is a suicide or anything else. They may have certain suspicions in relation to traffic crashes, for argument's sake, when they drive head-on into a pylon on the freeway or head-on into a truck; they may have some —

The CHAIR: If they are hanging from a rope, it would be pretty obvious.

Mr M.J. COWPER: But I find it interesting that you are saying they should go back and do more at the scene and they should take less of a legalistic approach. That is very well in retrospectivity or in hindsight, but when you are actually on the ground in the middle of the Great Sandy Desert, 300 kilometres from anywhere, and you have got yourself and your buddy trying to deal with it in 50 degrees heat, it is somewhat problematic.

Prof. Lawrence: I agree. I did not in any way mean to imply that that work should not be done or should be in any different way. I am just suggesting that there is an additional role —

Mr R.F. JOHNSON: It should be done afterwards—yes, an additional role.

Prof. Silburn: I remember when I was in Western Australia, we dealt with the police coronial inquiries branch and one of the issues that the —

Mr M.J. COWPER: You are fortunate, because we never got a chance to do that. You were it.

Prof. Silburn: One of the—I think it is called the standing orders for what police officers need to be do when they are investigating a suicide is very much written from the point of view of an adult suicide, and with the increasing number of child and youth suicides, there is other information that we would like to see police asking for on a routine basis, which is readily available. Is there a file in the Department for Child Protection services? Does the education department have a file on this kid,

because a lot of the issues in the run-up to child and youth suicides—that information is not automatically volunteered by a family but it is part of the official record that is available.

Mr M.J. COWPER: It may be available to the coroner, but it is not available to the police officers, and quite often you will find that there are reasons why they will say, "Well, no, you don't have access to someone's medical history."

Prof. Silburn: Sorry; the coroner does have that power. The police could ask some of the questions that are asked routinely about involvement with—difficulties at school and all of that —

Mr R.F. JOHNSON: I do not see it as a criticism against the police, Murray, to be honest.

Prof. Silburn: Absolutely not.

Prof. Lawrence: The point is well taken.

Mr M.J. COWPER: I know; it is just that it is such a broad task and it is very easy to sit back and read and make an assumption based on research.

Mr R.F. JOHNSON: The reality you are advocating is something post the actual police investigation of the initial death.

Prof. Lawrence: Absolutely.

Prof. Carapetis: The philosophy is: what is the evidence that you need that will best inform things to do to prevent future suicides?

Ms J.M. FREEMAN: Could you not do that in a more proactive—is it not possible that if you did good postvention suicide—let us say it is a remote community and you did good postvention suicide delivery into that community, if the coroner could, or if that person could be given—could you do a dual responsibility or is that mixing it up too much? Could you have someone who is doing that postvention also be able to give feedback to the researchers about the social context of those sorts of things, or does that mix up the two roles too much?

Prof. Lawrence: I think it would be very valuable to have people involved in the postvention activities as part of the investigation as well and at least providing information back to the researchers.

Prof. Silburn: We did have a program like that in Western Australia several years back called the ARBOR program, and it was initiated through the coroner, and there were a number of trained counsellors who worked with the police and were available, and police could give a card to say, "Look, if you're wanting some additional support, you can ring this number. They are professional counsellors who can talk to you about the sorts of things that you're going to have to deal with for the coronial investigation process and all the things that you may need to think about over the next few weeks", when they are still spinning from what has happened. That program worked for two years. Again, it was one of these commonwealth-funded things. Funding ended, program ended.

Ms J.M. FREEMAN: Is that not interesting because I still have a magnet on one of my filing cabinets of the program. So I did not know that the funding for that had ceased.

The CHAIR: David, is there anything to be said around the—I will call it delay? There is a fair time between what proved to be a suicide incident and the data and the statistic. Sometimes there is a fair lag time. Do you have any comment about that?

Prof. Lawrence: The way we are establishing the new coronial suicide information system, it has multiple roles. One is to support research and collect information in the longer term, but another part of it is what is being called the real-time WACSIS, which is based on publishing the information onto the database as soon as possible after the death is reported, so once the first report comes into the coroner's office, the death is entered into the database. The database will be accessible by both the Mental Health Commission coordinating the suicide postvention activities

and the coronial staff within the State Coroner—there is a memorandum of understanding being prepared between the agencies to support that, the idea being to make sure that the data, as much as is available at the time that a suspected suicide death occurs, is available for the purpose of being able to support the postvention activities and also to try and identify if there is evidence of a cluster emerging in a particular location or if any particular trends are emerging around particular methods of suicide or something like that that support the intervention activity. We are trying to set up the database to have the capacity to address both of those critical needs.

Prof. Silburn: Could I make a comment, please, with regard to the question that Dr Jacobs asked about the evidence about the long-term influences on what leads a person to become at risk of suicide. We reviewed that for the "National Strategy on Aboriginal and Torres Strait Islander Suicide Prevention", and there is a section in that report called "Changing the discourse" on suicide prevention", and it deals with the fact that almost all of the efforts by government to date in trying to address suicide have been targeted at the end point, too little, too late when it is much more difficult to do things.

[1.00 pm]

There is a diagram in that section, which I can circulate, that sort of summarises a lot of the factors and the social determinants, if you look at the life course of individuals, starting from the bottom left-hand corner moving up to the top right-hand corner, where we are looking at suicide as the outcome. As you move up, we know that there is now good evidence about the effects of early life adversity on the developing brain, both prenatally and in the first few years of life. That provides either a sturdy or a fragile foundation for self-regulation of emotion, attention and behaviour. That sets up—when kids arrive at school, the capacity that they have in terms of self-regulation of emotion, attention and behaviour is going to be the thing that predicts their success at school and their social outcomes later on in life. It is also highly predictive of whether or not they are going to land up in contact with the justice system or end up with drug and alcohol problems or mental health issues or suicide. What this diagram does is summarise an enormous amount of literature that sort of identifies what are the most common risk factors that you see, and they are different at each stage of development. Most of these are preventable in one form or another, but they all require different strategies and different sections of government have the capacity to influence them. So, no one department can deal with this; this is a whole-of-government, whole-of-community initiative.

You heard Sir Michael Marmot's second Boyer Lecture on Saturday. He spoke about the role of social inequality, and why you get much higher rates of all these problematic issues that are of concern to governments in highly disadvantaged populations, and it does take generational reform to shift those outcomes, and I think that the Closing the Gap strategy recognises that. The strong advice we gave to the commonwealth government is there has to be an equivalent generational strategy to address these long-term causes of suicidal behaviour, and it will have many benefits for society generally, not just in preventing suicide, but in reducing rates of Aboriginal incarceration, and better educational and vocational outcomes for Aboriginal children and youth.

The CHAIR: One of the things that we grapple with is that, in delivering a service—as you rightly point out, it is often all at this end, when it is basically may be too late—then it is on the reform, and the reform along the way and the things that you can do in the steps in this flow diagram. One of the things you grapple with, I think, as legislators, is that everybody has got a bid in here, and we are not really sure who has carriage of it, and who is actually going to drive it, and who has got ownership. Whether it be delivering the services, admittedly at the end, in Roebourne, with 95 or 93 people or organisations providing services in Roebourne—as we heard from Tracy Westerman, 43 organisations delivering services in one community—who takes ownership and guides that? I have this problem as a member in the goldfields. I will go along in desperation to the Department of Aboriginal Affairs and say, "Who's got carriage of some of the social determinants in the community that is leading to some of the social dysfunction?" I get belted around between them and

an organisation called the Indigenous coordination unit, and I thought, coordination sounds good, I will go to them. We need something about coordination and how we are going to drive all this reform. I do not see it, and I do not have any answer, and I wondered whether any of you gentlemen have some idea about, particularly in relation to Aboriginal youth suicide, who is going to have ownership and drive this in the community.

Prof. Carapetis: Can I speak to that please? You have struck a point that I feel is critical, and, to be honest, it comes back to the Closing the Gap strategy and what has happened since then, and inevitably it is about how government functions, is it not? It is about trying to take big targets and then come back to some interim indicators, and then what we are going to do to meet those interim indicators, and it comes back to someone who is there to make sure that that is delivered, and they try to identify two or three services that could potentially meet that indicator. In the end, they are going to be judged on how they deliver something that is more of an input or a process indicator, as compared to an outcome indicator. So if you look at Closing the Gap, quite a few of the interim indicators have nothing to do with actually achieving the outcome, and we have created a system whereby it is service packed upon service, and what do you do to coordinate it? You whack on top of that a coordination service. If you were designing from scratch, there is no way you would design what we have got now; you would never design what is happening in Roebourne right now.

So, what are the opportunities? The first opportunity is to say that, up until now, everybody has always assumed that it is the government that has got to sort it out, and I do not know of a single problem in Aboriginal health and wellbeing that has ever been solved by government. It is usually solved by communities taking control and by a whole lot of other sectors coming in and working together with government as one essential partner. Essentially, the way you would like to be able to do it is to scrape everything to the side and say, "Let's start again." Now, I do not know what the opportunities are for that sort of thing to happen, but, as a minimum, to identify that there are a whole lot of stakeholders that are really keen to see things happen, most of them community representatives and community leadership. Again, you look at the Kimberley, and you could pick three or four incredibly strong local people who could take some leadership of a program to make youth suicide history in the Kimberley. You would bring into that agenda a whole lot of people who are not necessarily from the government agenda. You might bring some captains of industry; you might bring in the economists from the national banks, and say, "Let's look at what the policy implications are, and let's cost them out." I think the problem is that we just assume that we have got to work within the existing system. We have got to work with a government-driven project, and I do not see that that has led us anywhere in the last 30 years in Aboriginal health and wellbeing, which is probably not the easy solution you are looking for.

The CHAIR: I suppose a model that came to mind while you were talking was the one about the Fitzroy Valley and FASD. It all started with June Oscar, who said to us, "We have to do something about the effects of alcohol on our community and our kids", and they drove that.

Prof. Carapetis: This is where you must not underestimate the potential of coming behind a single vision like that—a single vision about eliminating youth suicide. If you are going to do it, you know that you are going to have to achieve so much more. Eliminating FASD, we are part of that collaboration and a whole lot of partners are coming behind it. There are so many other benefits that are coming in terms of school attendance. The services that are provided for FASD are also being provided to kids with other neurodevelopmental disorders, but the focus is on, let us measure success by whether we get rid of FASD, and whether we can stop women from drinking during pregnancy. That singular vision is driving so much community change. I think if there was one thing you would do, you would identify the vision and the handful of really wonderful community leaders who could drive it, and I would get June Oscar, Ian Trust and Vicki O'Donnell. You would pick four or five people and you would say, "Okay, what's it going to take?"

Mr Pearson: That is why I do not work in government anymore—I work with Telethon Kids—because I have done that and try to go inside the space, go through at different levels with great ideas and the brilliance of it gets essentially constricted. My studies around one of the big things about being in the delivery of services is, risk is a huge issue. The fear of putting your minister on the front page because you made a mistake, or ending up in the Coroner's Court. It is managing risk, because you are working with highly complex families with big needs, and you only need one of those things to go off when you are working at that level, and if you look at the Gordon inquiry, that was not far away, in terms of the amount of people who are involved in that young Susan Taylor's life. We have still not attended to those issues, and I am not sure that it is going to be, as Jonathan has said, within these current constraints.

[1.10 pm]

I hope and wish for the reforms going on in the Kimberley. There is a conversation and we have been involved in those. I have been talking to them around their visions on how they better integrate these activities. The critical element in all of this is obviously around the community. It is a conversation they have to have. They want it and they can drive it. June's ambition was driven entirely because they went to a funeral every day for a year, except for two. They wanted to get rid of the rivers of alcohol. The fights they had to go through with their own community once they established it, and then with government. June will tell you about getting phone calls from ministers around saying, "Well, the grey nomads are going up here; they're not allowed to get a drink in the Fitzroy." I mean, goodness gracious; this lady is trying to stop this. There needs to be a better tuning-in, I think, of government to these issues in a way that they need to get permission. They do have a role. These people who work in these organisations are highly dedicated people. They want to really do good stuff; businessmen, policemen that I work with really want to do good stuff. They need a role and a way in. They need permission to be able to play in a way that allows them to meet their obligation and also work at a level that makes sense to the community. They are there and they can be done. It is just that we somehow struggle to highlight those over other things.

Ms J.M. FREEMAN: In terms of working in government, what is your view of how the Department of Aboriginal Affairs plays a role in coordinating this space?

Mr Pearson: Can I talk from personal experience, if I may?

The CHAIR: Please.

Ms J.M. FREEMAN: Are you happy to be on *Hansard* or are you happy not to be on *Hansard*?

Prof. Carapetis: He is safe; he has got a job; that is all right!

Mr Pearson: It has a fantastic legislative mandate and it makes sense to everybody. What it does not have, I think, is the overarching power and authority executed in the way that it has influence on the budgets of others. I think it could if it was given that authority. That is my experience of working with people from the team of DAA because I worked for the Department for Child Protection and Family Support for 10 years, and watched it struggle with those things around having this expectation and then having to rely on other CEOs and DGs to work in that manner. It is almost like the junior sibling of the family. I struggled with that. Where it has been really effective is when it has gone into the monitoring and evaluating and just being; just saying, "This is the data we've got; this is what's happening at the moment." I do not underestimate the complexity of the issues either but the notions of talking about intersectional collaboration—all of these—and cross-government issues; we say that all the time but there is no real mechanism internally to be able to do that in a way I think that starts to be doing things at a regional sense or a family and community sense. What June's and Ian's work is doing in empowered community provides that if you have a system that has an authority that can speak to another system like government, you will get better traction. When the ATSIC regional councils went on, there was never a mechanism for government to talk locally. That is really an important part. I know that is something Cliff has been interested in

around, "Well, how do we get some regional representation and have the conversation locally?" Without that, it is a whole range of people doing a whole range of things—for really good reasons, with good intentions. I am not saying they are bad people. It is the same in research. We have been doing the same at the institute; there is a lot of fantastic research. How do we bring that together with more meaning? I think that is the focus now.

Prof. Carapetis: What we have done at the institute is perhaps through the microcosm of our good work. We have basically said Aboriginal health is everybody's business at the institute. Glenn heads a team whose job is to provide the support, to provide cultural connections, to provide priority setting and hold us to account. But the research is actually housed within other parts of the institute. It is not unlike what the Department of Aboriginal Affairs is charged with doing, but he has real —

Ms J.M. FREEMAN: Do you get more funding than the Department of Aboriginal Affairs?

Prof. Carapetis: Possibly.

Mr Pearson: It has never been a question of resources, I would say. The nature of resources comes from different levels. It comes in; it comes out; commonwealth funds do this and the state does this. There are a lot of busy people. Then there is the philanthropic and then there are other community organisations. The thing that Jonathan is leading and allowing me to provide some direction around is: how do we bring all that together in a way that makes sense to a family?

Ms J.M. FREEMAN: How do you do that?

Mr Pearson: We get people together and they start introducing each other. "Hello, Mr Lungs; meet Mr Ears", for instance.

Ms J.M. FREEMAN: You said it yourself; the Department of Aboriginal Affairs gets everyone together from Treasury, Finance, Child Protection, Housing, Justice, Health, but if there is a junior partner who everyone says, "Nice to see you, I'll just send a junior along because I haven't got time today", do you think about doing a commissioner for children–type thing? In my case, the opportunity commissioner is more powerful than the commissioner for children used to be, but not so now. Do you have a commissioner role instead of a DAA role to coordinate that?

Prof. Carapetis: How we do it is that I take personal responsibility for it. It has got to be led from the top and it has to be clear to all parts of the institute that this is core business and you will be judged accordingly. We have made a statement of commitment to Aboriginal children and families—a public statement—which I was challenged by the Aboriginal community to deliver, on core promises and we have to deliver on them. Therefore, this is going to work only if the DAA knows that every single agency charged with delivering a service will be held to account and that is core business as a priority at the top. It has to be led from the top otherwise it is going to be —

Mr Pearson: There are 90 000 Aboriginal people estimated in the state. I think that is where data is really important. We can tell you where they live what the age demographics are. We need to get targeted information and make sense of that. We know the diversity; we have got all those things. We know it is three million or 2.5 million square kilometres in WA. We do have data that allows us to be a bit more precise in the way we go about. Jonathan had to lead a really ambitious fund and to push because we have got to be truthful in what we do. That is our personal challenge. That is not making any less statement around what the state government or anyone wants to do around generally resolving this issue either. I think what we do at the institute is acknowledge that in spite of our best efforts in the way we have gone about it, it has not created the effect we wanted. We want to maximise that.

The CHAIR: With your experience, Jonathan, you have a commitment and you put it front and centre and that is great. How do we know that and where are other agencies with all this, both inside and outside government? You read the blurb on the Department of Aboriginal Affairs and it all sounds great, but do we need someone to drive this and then ask all these agencies for accountability in this area? Do we need a commissioner? I understand that you do it. How do we

know that government agencies are delivering and really have a heart for it or whether they are just words? Are we giving it lip-service, not actually delivering? What was really scary for us was that you can go into an area and see all these people delivering stuff, or supposed to be, and then you have got a government, quite honestly, that is saying, "We need reform in this area because we have chucked a lot of money at it and we're not getting any results so we talk about reform."

Ms J.M. FREEMAN: A good example was that the government has introduced the suicide coordinator roles; it put out a press release, and the Aboriginal Health Council said to us, "We learnt about it by media release." How do you stop that from happening?

The CHAIR: And what do we need, Jonathan, to drive this?

Prof. Carapetis: If you look at the Northern Territory—I lived for many, many years in the Northern Territory, where now over a third of the population is Aboriginal and where the previous election was decided by the Aboriginal vote. That is when suddenly people have to say we have to take this seriously. You cannot live in the Northern Territory and not have Aboriginal issues front and centre; it is everywhere. I come to a state where the Aboriginal population is four per cent of the total population. Largely, they are up in the areas where you cannot see them. I am sure there is a commitment but it is not priority number one.

[1.20 pm]

The concept of having the rates of young people in Aboriginal communities killing themselves, which is perhaps the most tragic thing that can happen to anyone in their lives, and for it not to be a state emergency that this has to stop, everybody is concerned about it and this is why you are having this committee. I see the ministerial council's report, we have various groups in the media and we have a couple of suicide prevention officers who have been appointed. It is a coordinated overarching strategy, not a strategy that says, "We are going to track this each year until we get rid of this thing." In terms of how it is governed, I do not know what the right structure is going to be. Unless the state, and perhaps the government, lead a process that engages Aboriginal communities and other sectors to say, "We are not only going to have a task force; we are going to give it all the resources it needs to make a difference and we are going to track and we are going to hold ourselves to account", I think we are going to be fiddling around the edges. I do not have the solution about what that looks like but if there is one thing that we as a state are talking really seriously about the knowledge that we have, kids are killing themselves at extraordinary rates and Aboriginal kids are killing themselves at even higher rates and we just have to stop it.

Ms J.M. FREEMAN: One of the things that the Aboriginal Health Council said is that they have a 40-year history and they are all around the state. You said yourself that you went to something with KAMS. They are saying that they are a resource that already exists that could be used to coordinate this. Do you want to add anything to that?

Prof. Carapetis: I will say something and then I will get others to say something. Firstly, we all want to do something so we equally offer ourselves to be part of whatever a solution might look like. I think the Aboriginal community health organisations have an enormous amount to offer. I am a little bit more circumspect as to whether they should lead and coordinate. One of the problems I see is that we have seen that a lot of these solutions come out of the health sector, which is often more of a sickness sector. For example, many years ago I noticed when I was a remote community paediatrician, when you would go to a community, what is the one organisation that is open 24 hours a day that seems to have the most people in it?

The CHAIR: The hospital.

Prof. Carapetis: It is the health centre, and it is a place of sickness, it is a place of suffering. It is not a place of happiness and connection. If I go to my suburb where I live, what is the organisation—it is not open 24 hours—where people get together? It is the school. It is a place of positivity and connection. So my concern would be that if you charge the health system with

coordinating this, is this disengaging other sectors? I think I would want to be a bit more careful about that. Having said that, the community control sector have enormous strengths and they have to be a significant part of it. If they were to take a lead in this, they would have to demonstrate how they are successfully engaging all those sectors. Sven and Glenn probably have their own thoughts. I guess I am being a little bit careful.

Prof. Silburn: One of the points that Michael Marmot made in his lecture is that there are two ends of the problem that you have to tackle. One is at the local community level. I think Jonathan has talked about some of that community empowerment type but also local coordination. The other is at the macro policy level in terms of addressing the drivers of continuing disadvantage. Progress has been made. The things coming out of the Gordon inquiry have seen much better policing, which has led to much better community safety. That in turn is going to lead to long-term benefits. You are not going to have this pipeline of at-risk kids. The evidence would suggest that things could get a lot worse before they get better because of this long latency period in which all these risk factors have a cumulative impact. We have to be addressing the downstream end and we have to be addressing the upstream end. Different strategies are required at each end. At the upstream end you have to tackle the policy thing. It is about policy coordination centrally but you also have to look at policy service coordination at the local level—coordination and locating it where it has the best opportunity to make a difference.

Ms J.M. FREEMAN: Social justice, I think Marmot would say, would he not? We have lost social justice to economic imperatives now, have we not?

Prof. Silburn: Okay. If you are looking at what engages communities about what they want, they want their community to be sustainable. Mobilising around their children is something that gives them hope. They can get early runs on the board and they can see progress. That will be one of your first avenues where you see that you are making a difference and the community gets hope and can see that those kids are going to have a bright future.

Mr Pearson: You also have the children's commissioner. He's fantastic. He has some great ideas about keeping government honest about reflecting back the data and then, similarly, you have the Mental Health Commission, with Tim Marney, in terms of the work that they are seeking to do in terms of not only these programs but how to bring things relating to alcohol together. He has a lot of challenges in that space. They are also critical voices that are also important to have and they are something really powerful. I think you have witnessed here today with the Aboriginal people and watching these fantastic wetjala people talk really strongly around the things that need to get done is very powerful. The Aboriginal people have been saying for a very long time, very clearly around the things that need to be done, involving them in there. But when you get alongside the other people in your team, starting with your boss down, it creates a really critical set of conditions that really ask us to be honest with ourselves. As an Aboriginal person, some of the things that I am bringing to the game are actually standing in my way in terms of what I need from my community, and the same for Jonathon and the others in coming to that. That sort of level of conversation is happening and it will make a difference.

Ms J.M. FREEMAN: It is not without controversy, is it? You raised Ian Trust. We were up in Kununurra and the white card was a big controversy where we went. That conversation is in the community. We as leaders get people talking to us—those people on the ground, the people you are talking about. We went to a women's refuge when we were there. There was a really strong pushback about that for us, and wanting to be heard—the feeling that they were being disempowered and treated differently and disrespected by virtue of the white card. Do you want to add to that?

Mr Pearson: The proposition that Ian is putting—this is only my observation—is creating that conversation in the community around what sort of future do you want, and if you want to get there, how are we going to get there? Sven pointed to it. It is going to get harder before it gets softer.

Some of the things that we are going to lead at a community level people are not going to like. That is what responsible government does. It tells them the full story and says, “Right, we have to go.” If we want to keep burying our kids in terms of violence and those things, we have a role to play and we have to have that conversation with ourselves. It actually transcends the issue of cultural differences. It is around the community, acting on its own accord. I cannot speak for the women at those conversations but they are notions of what we do at a community level. It goes to the question of the community being involved and having that voice and driving those things. June was a perfect example. They were given death threats. The community really wanted it. There are parts in the community that did not want it for a whole range of reasons but they were not prepared to allow that circumstance to continue. It is significantly different. If you have the police reports, you know what is happening. The work that June has led in terms of the Murulu strategy and evidence-based response to this is not just about alcohol but a whole range of issues in this case.

The CHAIR: I think we have run out of time. Thank you, gentlemen, for your evidence before us today. A transcript of this hearing will be forwarded to you for correction of minor errors. Any such corrections should be submitted to us within 10 days. If you do not return it, we understand that you think it is pretty good. New material cannot be added via these corrections and the sense of your evidence cannot be altered. Should you wish to provide any additional information, we would be very pleased to receive it. If you wish to elaborate on any particular points, please do that too. Thank you again for your time today. Sorry we kept you for a little bit longer than you thought. We do appreciate your input to try to help with this very important but very challenging matter.

Prof. Carapetis: We wish you the best of luck because it is a very important inquiry. Thank you for the opportunity.

Hearing concluded at 1.30 pm

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