REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PREVENTION OF YOUTH SUICIDE IN NEW SOUTH WALES

At Jubilee Room, Parliament House, Sydney on Monday, 30 April 2018

The Committee met at 1:00 pm

PRESENT

Ms Melanie Gibbons (Chair)

The Hon. Wes Fang
The Hon. Paul Green
Ms Jodie Harrison
Mr Michael Johnsen
Mr Damien Tudehope

The CHAIR: I welcome everybody to the Committee and declare the Committee open. I thank you all for coming today. The Committee has already held a number of hearings as part of its inquiry into the prevention of youth suicide. Today the Committee will be hearing from a leading expert in Aboriginal and Torres Strait Islander suicide prevention, Professor Pat Dudgeon, from the University of Western Australia. As the Committee has mentioned on previous occasions, it is an important but sensitive subject which may affect many people in the room. The Committee is aware of this and I encourage you to contact Lifeline on 13 11 14 or Kids Helpline on 1800 55 1800 if you or someone you know needs help. Before we begin, I ask that your mobile phones be turned to silent.

PAT DUDGEON, Professor, School of Indigenous Studies, University of Western Australia, before the Committee via teleconference, sworn and examined

The CHAIR: Would you like to make a brief opening statement before the commencement of questions?

Professor DUDGEON: I do not know if the Committee knows my background but I was the team leader for the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project [ATSISPEP]. In that project we did a big review of Indigenous suicide. As you know, Indigenous suicide nationally is twice that of other Australians. If you break it down, in some age groups it is the leading cause of death for our young people. When you break down the statistics into age groups or location, more serious pictures can emerge. During that project, which took about a year and a half, as well as doing literature reviews, looking at the evidence, looking at evaluation programs in order to ascertain what worked well in Indigenous suicide prevention, we also did a series of roundtables across Australia.

One of these were with youth because we saw youth as being particularly vulnerable. That project ended in an absolutely amazing conference in Alice Springs where we were able to bring a lot of Indigenous people together, including youths. We had the Koorie Youth Group involved—I do not think it was a council then but it became a council—with Indi Clarke. He was very much involved with the youth streams we were undertaking. That ended up in our great report, ATSISPEP, with solutions that work, what is the evidence and what our people tell us. I am pleased to say that that report has been taken up by government. It has been looked at for doing good in Indigenous suicide prevention. Indigenous suicide is different to that of mainstream. I will leave it there—you might want to ask questions—because I can rave on and on.

The CHAIR: That is brilliant, thank you. You mentioned that the Indigenous suicide rate is different. What do you put that down to?

Professor DUDGEON: About 30 or 40 years ago there was very little Indigenous suicide or Aboriginal suicide happening, but over the past 30 years that has increased dramatically with young people, particularly 17-year-olds to 23-year-olds , being most at risk. If you look at our ATSISPEP report, we have graphs from the Australian Bureau of Statistics. When you see a graph with different lines across an age range, it is quite striking how the Indigenous rate is overall high, but particularly between 17-year-olds to 23-year-olds. There are a lot of reasons why Indigenous suicide rates are particularly high. I know people say that it is a bit distant but it is one of the consequences of the process of colonisation. If you all know Australian history, you will know that Indigenous people were subject to genocide, they were removed from their country and placed into missions and reserves, and so on. Then we had another way it happened, which involved the forceful removal of children from their families, what we call the stolen generations now. That all has its consequences.

We know from the Bringing Them Home report and whatnot that people who had been removed have more serious mental health issues. They are much more vulnerable. The factors that contribute to high Aboriginal and Torres Strait Islander suicide rates are very complex but interrelated and these can include the cumulative impacts of ongoing exposure to socio-economic disadvantage and multiple psychological stresses, and grief from the premature death of families, community members and friends, including suicide. I would say that there would not be very many Aboriginal families, but you need to keep in mind that we are talking about extended families who have not had a suicide in their families.

For myself, that is the reality as well. My people are from the Kimberley, which is considered a bit of a suicide hotspot, I suppose. For a lot of families there is violence, interpersonal conflict, trans-generational trauma, grief, loss associated with the impact of dislocation and the forced removal of children, and mistreatment. For a lot of Aboriginal Australians there is still pervasive racism and discrimination at individual, institutional and system levels. For some groups there might be—we worry particularly for young people—a sense of loss of purpose and meaning in life. Other factors that contribute are poor health, including a number of comorbidities, and severely compromised mental health and social and emotional wellbeing. Finally, there is an access gap for mental health services. Thirty five per cent of Indigenous people who reported high or very high rates of psychological distress also experienced access problems with health services.

As well as all of the other factors, there is not enough good services or programs available for people. It is all those things put together. We did 12 roundtables, six were regional, so they were in various locations such as Darwin, Broome, and Cannes—I think we went to Mount Gambier in New South Wales. We did six regional roundtables across the country, and six topical roundtables where we looked at specific things such as youth; justice; lesbian, gay, bisexual, trans, and/or intersex issues; clinical factors; and so on. As we went ahead we thought, "We really need to focus on this particular topic that we see as contributing, having unique factors, and

playing a role in suicide prevention. Our roundtables included mainly Aboriginal participants, which enabled us an opportunity to talk to the community and get their viewpoints on what the big issues were and what the solutions could be.

A lot of the big messages in the roundtables were around ongoing poverty. Poverty emerged as a big issue. Obviously we interviewed people and workshopped issues, so their responses may well have depended on what was happening in the community at the time—we cannot deny that. But from the roundtables the need for self-determination and local leadership emerged. We also need to consider the social determinants that help, such as employment, racism, housing and so on. A lot of people said, "Don't ignore the role of trauma, it is a big issue in our community." A lot of community members saw incarceration and justice issues as being very much connected with suicide, and the need to build a strong culture and identity. I am sure the Committee has already seen the ATSISPEP report but we can send the link if the Committee needs it.

The CHAIR: Thank you, what an interesting report to be part of. Those roundtables sound incredibly interesting.

Ms JODIE HARRISON: Thank you for addressing us today, Professor. In your opening statement you made a comment about Indigenous suicide being different to mainstream suicide. What I heard was that it was not necessarily only the rates but also the nature of Indigenous suicide. Would you like to expand on that point?

Professor DUDGEON: I would like to underline that comment. Indigenous suicide is different because we have the history of colonisation and because there has been a disruption from cultural ways. The process of colonisation meant that Indigenous people were taken away from their countries and were treated like second-class citizens. It has been a hard journey for most Indigenous people. We are not alone with this. For Indigenous people in settler countries—as I will call them—where the Indigenous population is still part of the nation, such as the United States, New Zealand, Canada and so on, there are very similar situations.

We have been talking to our international peers and Indigenous peers and it is pretty much the same situation. There is a need for Indigenous people to go through a process of recovery—which is happening—and of cultural reclamation and the gaining of self-determination. I support the Commonwealth-funded Kimberley suicide prevention trial site, which has been working with different communities to look at becoming empowered and choosing a good program that they could develop and deliver. We cannot ignore—I think maybe for non-Indigenous suicide as well—the social determinants that surround people. If someone is poor and disempowered, a lot of what we do is not going to be very effective. Does that answer your question?

Ms JODIE HARRISON: Absolutely, thank you.

Professor DUDGEON: We should have sent this last week—I have been travelling, so I apologise—but another good report is the "Elders' Report into Preventing Indigenous Self-harm and Youth Suicide". If Committee members have an opportunity, they should look at the report, which included about 17 different elders from across the nation who were part of a project that Culture is Life undertook. They talk about their concerns for youth. The focus was on concerns about youth suicide from the voices of our elders.

The CHAIR: Excellent. One of my questions was going to be about the role of elders, so thank you. We will read that report.

Professor DUDGEON: It is very good. Jan will send you the link if need be.

The CHAIR: Fabulous, thank you.

The Hon. WES FANG: Thank you for addressing us today, Professor. Victoria and Queensland have suicide registers and the Committee has received evidence about establishing one in New South Wales. Would you support a suicide register and, if so, what should it include?

Professor DUDGEON: Yes, I would. I am envisioning that it would be to deal with the issue of real time data, yes?

The Hon. WES FANG: Correct.

Professor DUDGEON: That did come up and when we did the ATSISPEP report. A lot of people said, "We want to know what is happening immediately so that we can deal with it." I think a suicide register does have good merit. What I would be doing though is ensuring that appropriate Aboriginal community stakeholders were involved—for example, what is the New South Wales equivalent of the VACCHO? We do have mechanisms in place that are powerful and good, such as the coordinators and State affiliates for the Victorian Aboriginal Community Controlled Health Organisation, and that is often where we go for ethics

approval. The organisation is very sophisticated and knowledgeable about Indigenous issues. I would have them involved.

The Hon. WES FANG: For Hansard's benefit, you mentioned a group named "VACCHO". Is that a Western Australian group?

Professor DUDGEON: It was not data processing; it was more Indigenous engagement. It is the National Aboriginal Community Controlled Health Organisation.

The CHAIR: What was the name of the group?

Professor DUDGEON: VACCHO is the group in Victoria. I will find out the name of the group in New South Wales. Each State has one. They are independent but they come under the National Aboriginal Community Controlled Health Organisation. Usually when we get ethics approval, we will go through those groups. They are well established and reputable.

The Hon. PAUL GREEN: I refer you to the data collection for Aboriginal suicides and the impact of child sexual assault.

Professor DUDGEON: Addressing child sexual assault and child abuse does play a role in suicide prevention. Initially we were cautious about including that, but it is certainly in the Aboriginal and Torres Strait Islander Health Performance Framework report. We had a long conversation with Professor Helen Milroy, an Indigenous psychiatrist who was also involved in the royal commission investigating child abuse. We did include it, but we were apprehensive because we were concerned that if suicide was seen as being strongly linked with child sexual abuse it would be a case of blaming the victims and the families. We cannot deny it, but there is a range of other factors. However, experiences of child sexual abuse or any form of abuse definitely do contribute to suicide. As Professor Milroy put it, it might not provide a tipping point but with a number of other factors it creates complex and interwoven factors that may well lead to suicide. Not everyone would have experienced child sexual abuse, but it is one of the factors.

The Hon. PAUL GREEN: What wraparound services are available for Aboriginal children who have tried to take their life?

Professor DUDGEON: It varies from place to place. I am not familiar with New South Wales, but I imagine the Committee will be speaking to the appropriate Indigenous stakeholders. As with any mental health issue, we need a stepped-care approach. I have found that communities like to deliver universal programs that bring people back to country and strengthen their culture and identity. We certainly need those programs. However, we also need immediate programs so that when children are in distress we can get a psychiatrist or psychological service immediately. There will be different needs for different issues. There should be a smorgasbord of different offerings, some of which could be based in the community. Some of the Aboriginal medical services have clinical psychologists and psychiatrists on their staff. However, more attention should be focused on the developmental needs of Indigenous children.

Mr DAMIEN TUDEHOPE: You were very expansive in your assessment of the psychological makeup of people who potentially are at risk of taking their own life in circumstances where you have identified alienation, whether it be in respect of the stolen generation or as a result of the perception of Indigenous genocide. How do you know that?

Professor DUDGEON: Probably because a lot of mainstream activities have failed. Also, our philosophical approach relies on the work of Professor Michael Chandler with the Canadian First Nation people. The research looked at the suicide rates of various tribal groups or communities. When they desegregated the statistics they found that some communities had no suicides or very few and others were off the chart. They investigated the communities that had no or few suicides and they found certain factors, such as doing activities to build self-determination. They called them cultural continuity factors.

It involved communities being in charge of their own police force, child protection services and so on. They later reanalysed the data and found that having women on councils was another factor. That was not because of the magical influence of women but because the community was very fair and not misogynous. Having cultural activities like building a long house or dances was also considered a factor that contributed to a low suicide rate. That is also what the community tells us. We know that mainstream solutions have not worked to date for Indigenous people and that we need to try innovative and new ways of approaching issues.

Mr DAMIEN TUDEHOPE: Have we done a similar analysis in Australia of some Indigenous communities that have few or no suicides as opposed to those communities that experience many suicides?

Professor DUDGEON: No, but it is different. Why would we have not done that? I think we should be unpacking the rates and looking at what is happening in the communities. We started the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project to unpack the data. Our populations are also small and statistically we can lose some of the meaning. If there is one suicide or two suicides in a small community it can skew the ratios. That is an issue. That said, we should be looking at it.

The Kimberley is seen as a suicide hotspot, but the community is very diverse and whether we would get meaningful data is questionable. We have done a report with the Healing Foundation that is yet to be published. The foundation sent researchers into two communities in Yarrabah in Far North Queensland and Arnhem Land. The research group already had a relationship with the communities and it was able to use that good relationship to interview community members. They were hotspots and the community in Arnhem Land was the subject of mega news media that shamed the residents. When the research was done, they decided to take charge of the situation and to turn things around. As I said, the report is going through its final draft and it will be launched later this year. We have gone into areas with very high suicide rates that have decreased. We were interested to hear from the communities about what contributed to that turnaround.

Mr DAMIEN TUDEHOPE: The Hon. Paul Green referred to this matter earlier but do you agree with me that the suicide rate in some communities where there is a high rate of sexual assault offending may be significantly higher than in other communities where there is no offending?

Professor DUDGEON: We would have to investigate. We are not denying that there is a connection between experience of sexual abuse and suicide, but I would be very uncomfortable to make that statement in that fashion.

Mr DAMIEN TUDEHOPE: Do you agree that the potential best solution, if you were to draw on the Canadian experience, is in circumstances where there is strong community support for young people within the community?

Professor DUDGEON: Absolutely. We see that youth want their communities and their elders to support and look after them, and the elders want to support and look after their youth. We cannot deny that some communities have got big issues and challenges, so it is trying to help them do what they want to do anyway, which is to support their children and their communities. How do we do that? If a child is in danger we do need to remove them from a situation but we have seen the consequences of the stolen generations. We know that was a tragic and terrible event in Indigenous history that now has far-reaching consequences. So trying to keep families and communities together and to assist them would be a way to go rather than punitive reactions. Sorry, I do not know if I have rabbited on too much.

Mr DAMIEN TUDEHOPE: No. It is interesting because there is a correlation between Indigenous offending rates and, I suppose, dysfunctional Indigenous families. Can the same correlation be made between Indigenous self-harm rates and dysfunctional families?

Professor DUDGEON: It may well, but I would say that research in the proper way in a community-empowering way would have to take place to investigate that. I think it is easy for us to search for a quick answer for things. I think how we get the answers is important. The same when we did the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project [ATSISPEP]—we could have sat in our offices and not gone to the community and got their opinions. We were a bit apprehensive because, you know, Aboriginal people say they get consulted and researched to death and then nothing ever happens. So we need to be mindful of that.

But still and all, people were pleased to talk and to give their perspective. So I think it is how we go about it and whether various communities are involved in the decision-making. I would say, yes, do take action if a family and individuals are in distress but it is how you do that with the involvement of those families and communities which can make it an empowering situation that has good outcomes or a disempowering, punitive situation that will be a cycle and nothing much will change.

The CHAIR: Professor, you mentioned earlier an access gap with mental health programs and services. Are you aware of any successful services and programs specifically for Indigenous young people that you would recommend to New South Wales?

Professor DUDGEON: Absolutely. There are some examples and after ATSISPEP, I am very pleased to say, that we actually tendered and won a Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention. We have just started but a part of our job will be to go and get all the best practice programs and services and have that registered on our web site. I know already there are some good services like Winnunga Nimmityjah Aboriginal Medical Service in Canberra. They are a primary health service and provide

a range of different programs. They are very strong on mental health support as well and I think they have their own clinical psychologists who are part of the staff and whatnot.

There are some excellent examples. Another one is the Miwatj Aboriginal medical service on Elcho Island which provides counsellors who are trained community people. They look after their people with severe mental health issues. They have actually taken people from closed wards in hospitals and reoriented them back into the community. For children I am not as specific, but these are general services that would cover everyone from children to adults.

The CHAIR: Professor, you have been incredibly thorough and of benefit to our Committee. The Committee may wish to send you some additional questions in writing.

Professor DUDGEON: Yes, please do. I have been travelling. I have got a terrible cold and I was thinking I would actually tried to have found out more about the programs in New South Wales. I have not had an opportunity but I am confident that you will be speaking to relevant people who will provide that information. I did feel I was not entirely ready for my conversation today but if you need any more information do not hesitate to ask me.

The CHAIR: Those replies will form part of your evidence and will be made public. Are you happy to provide a written reply to any further questions?

Professor DUDGEON: Yes.

The CHAIR: I want to place on record my thanks to Professor Patricia Dudgeon who appeared today and members of the public who have shown their interest in the Committee's inquiry. I also thank Committee members for their contributions and to Hansard and the Committee staff for their work today and throughout the Committee proceedings.

(The witness withdrew)

(The Committee adjourned at 13:37)