COMMONWEALTH OF AUSTRALIA

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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Suicide in Australia

TUESDAY, 2 MARCH 2010

BRISBANE

BY AUTHORITY OF THE SENATE

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SENATE COMMUNITY AFFAIRS

REFERENCES COMMITTEE

Tuesday, 2 March 2010

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

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

Senators in attendance: Senators Adams, Boyce, Furner, Moore and Siewert

Terms of reference for the inquiry:

To inquire into and report on:

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

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

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

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

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

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

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

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

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

WITNESSES

Committee met at 9.02 am

DALGLEISH, Mr John, Manager, BoysTown

BRUNKER, Mr Dean, Program Manager, Employment, Education and Training, BoysTown

CHAIR (Senator Siewert)—The Senate Community Affairs References Committee is continuing its inquiry into suicide in Australia. The Senate committees are currently trialling webcasting the proceedings of interstate public hearings. This means that your evidence will be available to be streamed via the Parliament House website in addition to the usual *Hansard* transcript which is always made. If witnesses have any concerns about the process, I would ask them to raise them with the committee secretariat before commencing their evidence.

I welcome the representatives from BoysTown, Mr John Dalgleish and Mr Brunker, who is yet to arrive. Mr Dalgleish, I understand you have been given information on parliamentary privilege and the protection of witnesses and evidence?

Mr Dalgleish—Yes, that is right.

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

Mr Dalgleish—Thank you. We firstly wish to acknowledge the traditional owners of this land on which we meet. BoysTown would also like to thank the committee members for the invitation to appear here to speak about the critical issue of youth suicide in Australia. So thank you for your invitation.

Kids Helpline responds to 11 contacts a day from children and young people who disclose thoughts of suicide or the intent to commit suicide. In our submission to the committee we have provided in-depth analysis of the 12,351 contacts received by Kids Helpline since 2005. As part of this analysis we have provided a demographic and location analysis, as well as the common problem types associated with suicidal feelings, preferred methods as well as risks, and protective factors. In summary, Australian youth contemplate suicide where there are feelings of depression and anxiety caused by unresolved trauma, often relating to abuse and sexual assault, and/or there is social disconnection and isolation due to relationship breakdown and the absence of support networks.

For Indigenous communities, these issues are even more striking. In Australia, Indigenous youth, depending on gender, are three to five times more likely to commit suicide. Conflict and relationship issues with family and partners, together with mental health issues, are precipitating suicidal risk factors. However, it is evident from our consultations and interactions with Indigenous communities that the dynamics around Indigenous youth suicide are more complex than these statistics indicate. Aboriginal people believe that mental wellbeing comes through achieving a balance and positive connection with family, community, culture and place. Family disruption caused by historical government policies that led to the creation of a stolen generation, a loss of culture and, consequently, to loss of self-identity amongst contemporary Indigenous youth, and which have resulted in ongoing barriers to participation in education and employment, contribute to the continuation of cycles of despair and hopelessness that lead to the high risk of suicide amongst Indigenous youth today.

It is our belief that suicide prevention requires a dual focus. Effective intervention strategies need to support at-risk individuals and/or groups, as well as improving our community's capacity and capability to engage with young people, particularly those who experience social exclusion. At an individual level, key strategies BoysTown would like to highlight include the need to ensure coordinated follow up, and the provision of psychological support to at-risk individuals post discharge from hospital. There is a plethora of research currently available indicating that very few young people who are hospitalised in relation to acts of suicide are actually provided with the support they need post hospital. In fact, the recent research bulletin by SANE indicates that 80 per cent of respondents were not provided with any support post discharge, even though that is a very critical time.

We also believe that intervention and engagement strategies need to take account of young people's contemporary communication and help-seeking preferences. Young people access the internet for health information and support in relation to complex problems. Our report showed that Kids Helpline receives a significantly higher proportion of contacts involving suicide through email and on-line counselling modalities. From a policy perspective greater emphasis needs to be placed on developing evidence based e-health strategies to engage young people about suicidal behaviour.

We also need to restrict access to preferred lethal means of suicide amongst young people. Young people's preferred methods of suicide are different to adults—and it appears to be the use of drugs and cutting. In our data we identified that many of the drugs that young people stated that they could access were prescription drugs, often prescribed for depression, anxiety and psychosis. Educational programs needed to be conducted to raise awareness of the risks involved in allowing uncontrolled access to these drugs by young people.

We also believe that it is important that social enterprises and mentoring programs be developed which have a direct contribution to developing the individual resilience of young people. Research being conducted in partnership between BoysTown and Griffith University is demonstrating that placement of at-risk young people in social enterprises develops protective factors that lessen the risk of suicide. So we need to get away from a medical model approach and look at community engagement strategies around employment and psychological support, which are critical to divert young people from suicidal behaviour.

At the community level we also need to enact strategies to ensure that services are coordinated and developed in a consistent way in response to this issue amongst young people. In our submission, a community developed model, which we are trialling in partnership with the elders of the Balgo community in the southern Kimberley, is provided as an example of such as strategy. In summary, responses to suicidality amongst Australia's young people require government and the community to treat the situation, as well as the person at risk.

Senator MOORE—Good morning. We have a short time and we want to share the questions around. I have two. The first one is about coordination. That seems to be a huge issue throughout the submissions. From your perspective, in terms of the range of services that have been funded and non-funded over many years, is there a strategy of coordination? And, even if there is one, how can it be done better? Our own view is that there seems to be fragmentation and lack of a network in terms of people sharing knowledge and expertise. Good morning, Mr Brunker.

Mr Brunker—I had to swim from Jimboomba! It’s a long way; I am sorry.

Senator MOORE—You have done very well.

CHAIR—Mr Brunker, could you tell us the capacity in which you appear, please.

Mr Brunker—I am a program manager for BoysTown. I am located in Kingston. I run programs for ex-offenders and for Indigenous people.

Mr Dalgleish—Dean is being modest. He is also a very experienced foster parent of Indigenous young people and a youth worker. He can give the committee a lot of insight into the day-to-day challenges that he faces in diverting children and young people from suicidal behaviour.

Getting back to your question, Senator Moore, we believe and we have outlined in our submission that pathways to the hospitalisation of children and young people who are engaging in suicidal behaviour have improved over recent times, particularly with the government’s investment in mental health services. However, the gap appears to be post-hospital. There really does not appear to be any form of coordination of response to children and young people or indeed for any person in that situation post-hospital. The reasons for that are varied. In the community sector and health sector there still seem to be artificial silos and barriers to coordination. People have different frameworks for intervention, people have different language and different culture. People do not know what services exist in their local community. All those things add up to a lack of coordination.

One of the things that we believe is an encouraging sign is wraparound care models of case management. In other words, you can have a situation where you have a number of specialist agencies networking and supporting a child or young person and that will work if there is a consistent case plan for that child or young person. It will only work if that is there. Again, in our submission we noted that currently Kids Helpline is often used as a safety net for children and young people in those coordinated wraparound care models. Because we are a 24/7 service we are always accessible, and this helps practitioners and agencies encourage children and young people to contact us in those hours of 12 to dawn when young people go into depths of despair. I really would encourage the inquiry to look at issues around how we can develop wraparound care models for these young people most at risk. As I said in my opening address, 80 per cent of children and young people and indeed adults generally do not get any support post-hospital, even though we know that one to 14 days post-hospital are the critical times for re-emergence of suicidal behaviour.

Senator MOORE—I have got to wrap my second question into a very big question. You may need to take this in groups. I am particularly interested to know whether your organisation works with or is aware of two of the government key areas, one being the CSS centre in Melbourne, which is the information hub, and also your involvement with the Griffith University centre in terms of how you are bringing the knowledge that you have in the field, which is well documented, into those two areas. The second part of the question is, how reliant are you on government funding? If the government actually pulled funding out tomorrow, how would you be able to continue operating?

Mr Dalgleish—In terms of the information hub in Melbourne, we have had no contact with that. In terms of our relationship with the Department of Health and Ageing, they have provided Kids Helpline with funding over the last three or four years in relation to broadening our engagement with children and young people on mental health issues. That funding has enabled us to train our counsellors, to conduct information strategies and communication strategies for children and young people around Australia and also has allowed us to develop an interactive website where children and young people can access that to immediately find out authentic information in relation to depression and anxiety and many other issues. That has led to about a 40 to 50 per cent increase in children and young people contacting Kids Helpline on mental health issues in recent times.

In terms of the Griffith University research—and I think Dean would be able to give some examples of this from his direct experience—the telling impact of giving young people who have been marginalised and have had long-term unemployment issues a mainstream job with the support, including psychological support, of our agency is that their whole sense of optimism and of future aspirations increases amazingly. As we all know, that optimism is the bedrock for resilient behaviour.

This year we are looking at nine publications that we will be co-writing with a group of academic staff to emphasise the importance of social enterprises in re-engaging children and young people in education, employment and vocational training. But—I will throw this up here—social enterprises need to be supported by government. They need to have an industry development plan, in partnership with government, to support their continued growth and development. Up to now in Australia, it would be true to say that individual social entrepreneurs have really inspired that direction, but we need a more coordinated approach because this is such an effective way to engage these at-risk young people not only in employment but in all the benefits that come from that employment in terms of enhancing their wellbeing and optimism.

Kids Helpline is two-thirds funded through our own fundraising efforts. In other words, that is mainly BoysTown lotteries, donors and supporters and corporate support from Optus. That is two-thirds, and the other third is government funding—state governments in Queensland and Western Australia and also the Department of Health and Ageing. So, if government funding were withdrawn, our organisation is totally committed to continuing the work of Kids Helpline, and we would have to do whatever we needed to do to increase our fundraising efforts to support that service, because we are absolutely committed. Kids Helpline is the only service in Australia that provides 24/7 telephone, web and online access and counselling, so we believe it is a critical service that has to be maintained.

In relation to that, all senators would notice the current debate in relation to the withdrawal of tax inputs from the not-for-profit sector. I can only say for the record here that we have done our own sums, and that would have an enormous impact on our ability to continue our services. So, in the context of engaging at-risk young people, our ability to do that would certainly be curtailed if those taxation inputs which are provided by government, particularly in relation to fringe benefits for staff, are withdrawn.

CHAIR—Mr Brunker, do you want to make an opening statement before we go any further?

Mr Brunker—We did discuss that, and I was going to let John do the opening statement anyway, so that is okay.

CHAIR—Okay.

Mr Dalgleish—Dean, would you like to say anything about the social influences?

Mr Brunker—Certainly. I manage Participate in Prosperity, which is a state funded program for ex-offenders. It is a pilot program which started two years ago. The idea of the program was to get the young people coming from detention centres and prisons. As you know, it is well documented that people who have been detained in a prison or detention centre develop some mental health issues, so it works in with this hearing. With a lot of the social enterprises BoysTown run, we try to break even; we do not work at a profit or a loss. We try to break even with the program. The program funds are used to set up the program. It pays the staff wages and it pays for equipment and vehicle running costs for the program. I had set up with an external employer who is very empathetic to his prisoners. I have to praise him for doing that, because a lot of these young people have committed a lot of crimes, and he is willing to let them come into his area. If we had more employers like this in business, we would not have to rely on government contracts. It is working really well. The state government have funded us for another 12 months. What we do is to train the young people up for four weeks in landscaping and cabinet making, and then we get them out into the workforce and support them for 12 months.

The trouble is that when these young people come out of the detention centre and go back to the community, they have these mental health problems. They are not getting help when they go back to the communities. But, if they come into BoysTown, they come to our staff—we have youth workers and counsellors—and they are fully supported for 12 months. We can help them or we can refer them on to further counselling and further assessments if we need to. The fact is that they are actually coming into employment. A lot of employers will not employ ex-offenders. When you say that you have committed a crime, you are an ex-offender. The chances of them getting employment are very minimal. So we have to work with social inclusion projects to get them sustainable employment in order to keep them off the streets and to stop them from breaking into my backyard.

Senator ADAMS—I have several questions. This committee has been doing an inquiry into hearing. Do many of your people who come out of detention have hearing problems?

Mr Brunker—They have but I did not realise that there was actually some research looking into that. Some of them have got hearing problems but a lot of them obviously have slight autism. That puts them onto using drugs for self-medication, that then causes them to commit crimes and that is how they come to our programs. We are working with that. I did not realise that there was actually a focus on hearing.

CHAIR—We have another inquiry looking into that.

Senator BOYCE—It is another one of our many inquiries.

Senator ADAMS—It was just an opportunity to ask about that.

Mr Brunker—There could be some links. We have a couple of young people who have hearing problems and eyesight problems.

Mr Dalgleish—Just on that, at some of our locations where we have our work employment programs—for instance, in Adelaide—we are, with the cooperation of local medical practitioners, currently testing the hearing of our young people because we find that hearing impairment is often a factor related to young people's lack of literacy and numeracy skills. We are currently doing that. We are finding—just off the top of my head; I can give you the exact figures later—that in Adelaide, where we have about 60 young people going through those work programs a year, that probably about 10 to 15 per cent have some hearing loss.

CHAIR—We have taken a lot of evidence and have a number of submissions on our Senate website on the hearing inquiry.

Mr Dalgleish—Good.

CHAIR—You might want to have a look at it, because I think you would find quite a lot of interesting information there. If you have anything to add on hearing, we would love to receive that separately to our other inquiry.

Mr Dalgleish—Thank you for the invitation.

Senator ADAMS—Sorry about that, Chair, but I could not resist it. I am from Western Australia and this committee has been to Balgo. I would like to hear some evidence about how you have set the program up and how it is working.

Mr Dalgleish—It has taken a lot of time. The invitation from the community came through the De La Salle Brothers, who have been running school at Balgo since the early seventies. De La Salle Brothers are the owners of BoysTown. As you would know, Senator, there was growing concern about the suicide rates of young people in that community. We decided that we wanted a real partnership with the elders. We were not going to come in in any way that would impose our view of the world on that setting. We would only go in if the elders, after looking at what we could offer, agreed to us doing that. So there was a two-year period where we were simply talking to the elders in that community about what we had to offer. Some of the elders came down to look at our services in Brisbane. From that came an agreement that we would start with a social enterprise at Balgo in relation to the refurbishment of houses there.

As you would be aware, an inordinate amount of money is spent by government to private enterprise organisations to do building and refurbishment in Balgo. The business model that we discussed with the elders was that, instead of all that money going outside the community, why don't we use that money? We would employ local Indigenous youth to do the refurbishment under the mentoring of our manual arts people and youth workers. That gives an employment outcome to young people. It gives them training. BoysTown is its own RTO, so we can credit young people as they learn on the job. We can also back that up through youth work and psychological support and others. That is basically the model.

We are doing other things, too. We have set up a silk screening cooperative with Indigenous women. They are using their art to produce goods, which are then sold in the Broome markets and other places like that. We are currently evaluating that project. It is early days; but, in a nutshell, there are 12 young people involved in the refurbishment of that work. They are progressing towards a certificate II in construction. The anecdotal information from the community is that these young people are walking 10 feet tall. They have status. They have a self-belief. They have confidence. They feel that they are contributing to the community. Obviously, we are going to document all of that. We are doing an evaluation of that, together with a bloke called Brian McCoy. He has had a lot of experience in Balgo in relation to men's issue. You might have heard of him. In the coming months, we are going to work with their community in terms of the Balgo BoysTown story, as we are calling it. The early signs are that that initiative is working for the young people. We just want to quantify it.

Senator ADAMS—Do you have any ex-petrol sniffers on the program?

Mr Dalgleish—Absolutely. We have young people who have attempted suicide. We have young people who have, unfortunately, petrol sniffed, who have abused alcohol and so on. Dean, you can comment on this: what we are finding and what the Griffith research is showing too, is that, not only in Balgo—some of the young people from Balgo were part of the Griffith research—but also elsewhere, of the 27 per cent of young people who regularly use and abuse drugs, when they are employed in social enterprises, that figure falls to about seven per cent. Those sorts of benefits will come out of giving kids real mainstream work that is supported with psychological and other supports.

Mr Brunker—When you are working with young people who have been sniffers and who have been chroming for a long period of time and you want to get them into employment, it is a big step for to get them from chroming and sniffing down to just smoking marijuana. To us that is a plus. If they say to us that they have actually stopped chroming, they are coming into work and for their recreation they are smoking marijuana at home, we do not berate them for that. We say: 'Well done. Excellent. Now the next step is, "Let's move from there."' But that could take two years.

I am lucky that my ex-offender program is 12 months support, whereas some of the other ones, such as Skilling Queenslanders for Work—senators might be aware that that is a state government funded program—are generally only 16 weeks long. We can support them for only 16 weeks. The Green Army program is 23 weeks long. It means that we can only support them for that long. We then try to move them into another program so that they have still got the ongoing support—as John mentioned—that wrap-around support within BoysTown, because we can give them that support. But there is a big problem. When the young people from Balgo come out to Logan, you could see the difference in them.

We work with a lot of young people from Cherbourg. They go backwards and forwards from Logan to Cherbourg. A lot of the Cherbourg people are the same mob as those in the Logan area. But they are completely different in their nature and the way in which they think because their cultural identity is probably a bit stronger than it is for those whose cultural identity has been broken down. Cherbourg was a mission, so it is a bit different. You can see the social differences in there. Obviously, their reasoning for their drug abuse is a bit different from the drug abuse and mental health issues in the Logan area. It is a suburban area. They have different issues that bring them back to that drug use.

Senator BOYCE—Are those differences recognised by the participants?

Mr Brunker—Yes. They were taken to an AFL game when they were here, which was a delight.

Senator MOORE—That is outrageous.

Senator BOYCE—What is wrong with rugby league?

Senator MOORE—Taking Cherbourg people to an AFL game is just not on, Mr Brunker. You are actually putting my support at risk here.

CHAIR—We will ignore the football and continue.

Senator FURNER—Could I go back to the comment about accreditation out of your RTAs and what sort of accreditation they are getting.

Mr Dalgleish—Certificate I and certificate II. We are looking at extending that to certificate III.

Mr Brunker—That leads into further training. If a young person does it for six months and they can do a certificate I and certificate II, we will then refer them on. Some of our young people have gone into then doing certificate III. Some have actually gone into youth work, because some people who have been through that system make excellent youth workers because they understand the problems and the pitfalls.

CHAIR—Yes. We have met several of them.

Mr Brunker—So we do target some of them and refer them on to certificate III. So we have some coming out with certificate III.

CHAIR—You have probably picked up that we do quite a lot of work in this area. We have found that, even before certificate I, organisations have troubles getting funding because some of the kids need extra help before they start certificate I. We are finding that that is not funded. We have talked to quite a lot of training organisations and other educational organisations who have said they have had trouble getting funding for the basic literacy and numeracy.

Mr Brunker—BoysTown have got the BKSB, which is the same as at the TAFE. Every young person who comes into BoysTown gets assessed. They have a diagnostic system which they will go through and they will do a diagnostic assessment. That will give us a bit of an understanding of what level they are actually up to. Some are year 8, some are year 9 and some are year 10. We have also used that diagnostic assessment to get a young fellow into the Army, because he had lost his School Certificate and we could not get it. I am ex-military myself and I know what they are after. They are trying to get a lot of Indigenous people to go into the military.

So we actually used that assessment. We took it to the Defence Force recruiting and they said, ‘Yes, that’s fine,’ because that is a proper assessment, because it is recognised.

CHAIR—You have trouble with getting the funding, though. That is the issue that has been put to us. People say, ‘We want to offer this support, but we’re not getting funded for it.’

Mr Dalgleish—You are absolutely right. You cannot work with a young person if their other needs are not being met—their needs for accommodation, food, the necessities of life. We are fortunate in that sense, in that we have our own fundraising capacity, so that subsidises everything we do. But you are absolutely right: if you did not have your own independent funding, it would be extremely difficult to engage young people on pathways towards certificate I and certificate II, because—as you said, Dean—it takes a long time to engage young people to develop trust, to deal with their immediate issues and concerns before you can move them into issues like social enterprises and so on. So you are absolutely right: that is a problem.

The other thing we could say is that, because we are our own RTA, we can be flexible in how we deliver training to children and young people. Many children and young people fall foul of the TAFE system because it is regimented by time—you have got to do certain things by certain times, milestones. Particularly with Indigenous young people—as you just said before, Dean—there is a lot of toing and froing and a lot of mobility. They may work with you for a couple of months, go to Cherbourg for a few months and then come back. We can accommodate that because of the fact that we run our own RTA. The other thing is that we can give credit on the job, as I said before. For instance, with our fencing project in Logan, young people are measuring the distance the fence has to cover. That is a core competency that we can then acknowledge and accredit in a certificate II in construction. The fact that they have measured this distance is a core competency. So it is that sort of flexible delivery of training that is critical for these young people.

Senator ADAMS—I am just looking at recommendation 15. With the upsurge in use of mobile phones, I am just wondering, if a child rings the Kids Helpline and they have only got a mobile phone, how do you get on with trying to find out where they are? Secondly, I notice you have got some comments about payphones. Of course, they are being phased out. In a number of communities we have been to, the payphone has just been jammed with coins and does not work anyway. Firstly, with a mobile phone, how do you find out where that person is ringing from? Secondly, without payphones or land lines, how are they getting to you?

Mr Dalgleish—That is an excellent question, because it really is going to impact on all telephone counselling services in the future. Currently, if any young person uses a landline to call the 1800 number that we have, that call is free. If they use a mobile—and, now, around 62 per cent of our telephone contacts are by mobile—unless they are on the Optus network, which also includes Vodafone, they have to pay for that call. So that is an immediate barrier to accessing assistance. In terms of our work with young people on mobiles, our service is private and confidential, but it is possible to track the location of the caller or the number of the caller. However, we would only do that in very extreme circumstances: if there was risk to others or risk to the child himself or herself. So normally we engage a young person, we develop a therapeutic alliance, a relationship—our counsellors are very skilled in doing that—and then, in a collaborative way, we work through the issues with that young person. The counsellors have access to a referral database of over 8,000 services which have been accredited by us as being suitable to work with children and young people. We go through an accreditation process because we have a duty of care to those young people. If we refer them to agency x, we need to know that they are going to receive a professional service. So the counsellor would often ask the young person where they are if follow-up services were required and then they would access the referral database. So, if the young person was in Melbourne or Adelaide or parts thereof, or Bourke, through that database we would know what local services we can refer them to. All that costs a lot of money to maintain, of course, but that is critical to maintaining the quality of our services for young people.

In terms of moving forward, we are talking to the University of Sydney and also the University of Western Ontario in relation to a research project on the very issue that you raised, Senator Adams. What is very clear is that children and young people prefer mobile and wireless communication. In five to 10 years, our expectation is that iPhones will have become the predominant media and communication device for young people—their cost is dropping. The youth uptake of iPhones is enormous, as we speak. Also, there is 3G, and in America they are rolling out 4G. Our phones are going to have a tremendous capacity for videoconferencing and other functionality that we do not have now but will become more widespread. So what we need to do is look at ways in which that new technology can be used to engage young people in help-seeking behaviour.

The other thing is the whole issue of social networking. Children and young people use the web to develop virtual communities and support networks which can also involve their face-to-face friends. How can agencies like the Kids Helpline connect with those virtual social networks to engage young people on these critical issues that place them at risk? That is our challenge, and we believe that we have to develop an evidence base about how we can do that effectively. Dean, you have a recent example, don't you?

Mr Brunker—Yes, only the other day. I have currently got 13-year-old, 14-year-old and 15-year-old foster children—I have had them for a couple of years. The oldest one, who has just left home, is 17 and she will be 18 in a couple of months time. She actually went to independent living after she turned 17. We supported her, and she was put in a nice home after being with us for seven years, so we had her for a while. She has done well; she did cert III at school and come out with a traineeship. But she found it overwhelming when she was virtually handed over to the department of child safety after having been in our care. She had us as a security net, but when she got out on her own in the big, wide wonderful world by herself, she had to go to Centrelink and organise her healthcare card, because as soon as she leaves our care she needs to get a new healthcare card. She tried to apply for TAFE but she needed a healthcare card to do that, so she could not apply. She needed to get all these other things done as well, and it just overwhelmed her.

One day I was at home and I received a call from my wife saying that so-and-so had actually put on Facebook that she was going to commit suicide. Now, this is only three weeks ago. She wrote on there, 'My life stinks, my life sucks; I'm going to kill myself,' and then she hit 'send'. She had 200 and something friends attached to that, so as soon as she pressed 'send' it went to 230 friends. Her auntie in Sydney, who she still has contact with, contacted my wife and told her what she had written on Facebook. So my wife contacted me and I left straightaway and went straight to her house, but she was not there—panic, panic. I went straight to work and she was at work. I said to her, ‘What’s the matter; what’s the problem?’ and then she told me, so I said, ‘Come on, let’s go.’ So I picked her up and took her off.

That is how important internet and mobile phones are to the young people. Had we not had that, I am not sure what she would have done, whether she would have gone to talk to one of her friends, who was probably not in a position to assist her because she is only the same age; they are only 17-year-olds. It woke me up to the benefits of having Facebook and mobile phones for these young people. People say, ‘You shouldn’t have a mobile phone’, but when she did that about six out of her 230 friends instantly contacted her and tried to find out what the problem was. It was a great benefit. Luckily, it is all sorted out now and she is in a good space. It could have gone the other way.

Mr Dalgleish—Summing up, there are a couple of issues here the government can assist with. Firstly, young people will seek assistance through mobile technology, and that is costing them. How can the government lower the barrier of access to reputable sources of help for young people? As I said, 62 per cent of our contacts now are through mobiles. Secondly, how can government work with the community sector to develop an evidence base to look at these newly emerging communication technologies, which children and young people are using now in help-seeking? Children and young people are amazingly creative. They will experiment with new technology much more than I will. How can we get on the front foot with that and use those technologies to engage children and young people? If you go onto the web now, there are sites which children and young people can access, suicide chat rooms which talk about how young people can commit suicide. We have got to balance that ledger.

Senator FURNER—Out of the 8,806 contacts that you have had since 2005, how many would you have had post communication with? You just commented on the story of the young lady who went on Facebook.

Mr Dalgleish—We offer children and young people ongoing support through Kids Helpline. In any one year we would be case managing, in partnership with others and that wraparound care model that I spoke about before, up to about 300 or 400 individuals. So we are providing ongoing support. Children and young people can choose to have a continuous relationship with a particular counsellor. Often we do that in a team. There are two or three counsellors who know the child or young person, and that child or young person can ask for them, so we can maintain continuity of contact. As I said before, we believe that that is best done in partnership with on-the-ground services. What we can provide is 24/7 coverage and accessibility, particularly in rural areas where medical services and so on may be patchy and the cost of accessing those may be high for young people. We can provide that sort of thing but we also need the support of on-the-ground services to provide the face-to-face for children and young people. We need that partnership.

One of the key things we are advocating for in our submission is that government assist the community and the direct service delivery arms of government to develop a partnership model to support young people more effectively than we currently can across the sector as a whole because, as Senator Moore commented before, there is a lack of coordination currently amongst our services. We can fix that up.

Senator FURNER—I was interested in your comment about the young lady on Facebook. Conversely, do you have any stats in respect of online bullying? It is pretty evident these days that that is happening. Out of the statistics you gather have you identified to what degree that is happening?

Mr Dalgleish—Yes, since 2008 we have kept separate figures in relation to cyberbullying. I can provide the committee with an analysis of that. It is a difficult issue. A child might ring us up about depression or anxiety and then only through several different contacts will it become apparent that that is linked to a cyberbullying issue. Since we have been collecting data, we have had about 80 different cases that relate to cyberbullying, and from analysis of that data for another inquiry in New South Wales on bullying we found, consistent with international research, a high correlation between suicidality and cyberbullying and even face-to-face bullying. As you would be aware, cyberbullying can hurt the child more because it reaches a wider audience—potentially the world. So, yes, we can provide further information about that.

Senator FURNER—I appreciate that.

Senator BOYCE—We have already had quite a bit of evidence around the fact that the stigma attached to suicide is part of the problem with trying to get the services well coordinated. It is not all that long ago that attempting suicide was not only a crime but also a sin. BoysTown is connected with De La Salle Brothers. Could you talk about that interaction of the church and the service provider, please.

Mr Dalgleish—BoysTown is a service of the De La Salle Brothers. We have core values relating to delivery of our services, and those core values relate to social justice principles. We believe that we should respect every person as an individual in their own right. We believe in perseverance, and, as Dean said before, that is a critical issue in terms of the fact that it takes a long time to gauge some of the marginalised young people we deal with. We believe that we should do our work with commitment. You do not have to believe those values are part of our ethos in the sense of any Christian belief; you may believe in those values for some other reason. However, they are core values for us. For the lay staff who are working at BoysTown those values are very consistent with social justice. There really is no issue there. All of the work that we do is conducted in a professional manner. The brothers are not evangelical and BoysTown is not an evangelical organisation. We do not seek to do that in our work.

The other thing is that we have respect for diversity. We encourage and we work with children and young people across different cultures, religions—whatever. The ownership of BoysTown certainly has an impact on how we deliver our services. In fact, one of the findings from Griffith research is that that model of individual respect when working with young people is one of the key factors that produces results through our workplace services and so on. That is actually coming up in the research. So, yes, it certainly impacts in terms of the core values that guide the delivery of services but it does not impact in any way on the types of counselling we provide or the professionalism with which we conduct those services.

Mr Brunker—I just want to add that one of our brothers has set up a reflection room at our Kingston site for our staff because working with at-risk young people is a very stressful job at times. The reflection room is a chill-out room. He has literature and artwork from all denominations, and crosses and Jewish symbols to cater for all the different staff. Just the other week we allowed a young Moslem boy to use the chill-out room so he could pray, which I had never heard of before. I thought it was brilliant that they can come and feel secure enough to do that in a Christian organisation. That was great; it was really good to hear that.

CHAIR—Senator Boyce, one last question.

Senator BOYCE—Yes. I was intrigued to see that the ACU is starting a course in Moslem studies. Things get more and more interesting. This is probably a two-barrelled question, mainly to you, Mr Brunker.

CHAIR—One!

Senator BOYCE—I will ask it and see where we get. We often bundle Aboriginal and Torres Strait Islanders together. Are there any specific issues related to Torres Strait Islanders that BoysTown has identified in terms of suicide? You have some research here about foetal alcohol syndrome and suicide. Could you perhaps talk a little bit about your experience of foetal alcohol syndrome and suicide in Logan in Queensland.

CHAIR—Can we keep this very short, because we are over time and I need to make sure that we allow enough time for other witnesses. Perhaps, if there is more that you want to add, you can take it notice as well.

Mr Brunker—Senator, to the first part of your question, yes, there is a distinction between the Torres Strait Islander people and Aboriginal people. The problems that they have in the Torres Strait Islands are a bit different because the culture that they have is completely different. Yet when they come down they are all put together in the same group. You will notice that some of the services are not provided for Torres Strait Islander people. I have not time to go through it here—

Senator BOYCE—It’s all ATSI—

Mr Brunker—That is right. They think of islander people and Maori people in the same way, yet they are completely different cultures. The Maoris do not look on themselves as islanders, so it is the same problem there.

With the foetal alcohol syndrome a lot of research has been done into binge drinking and the effects on the foetus of drinking during pregnancy. A lot of study has been done. We spoke to an Indigenous professor who came out to BoysTown to help us with some of the stuff we had prepared for the Senate. The problem they found with the drinking was that the effect that it has on the foetus is not just physical; there are also some mental issues down the track, so it can be generational. And the mental health problems are not just now; they could have started a couple of generations back due to foetal alcohol syndrome.

Senator MOORE—Who was the academic you used?

Senator BOYCE—Is that the Canadian?

Mr Brunker—No, she is an Australian woman. She works with the Canadians in research. I am sorry that I did not have her name here.

Mr Dalgleish—It would be true to say, Dean, that now the link between depression, anxiety, suicidal behaviour and foetal alcohol syndrome is emerging there is a need to do further research to look at the issue.

CHAIR—Maybe you can take it on notice. Foetal alcohol syndrome is also another area that this committee is very interested in.

Mr Dalgleish—I do not want to speak on your behalf, mate, but I know that the Indigenous community in Brisbane and Logan is very interested in looking at that issue.

CHAIR—Okay. A number of us have a very strong interest in that area. Thank you very much. As per usual, we have run over time—and the same thing happened yesterday—because we are also passionately interested in this issue. Thank you very much for your evidence. If there is anything else that you wanted to add, please feel free to send it into us. We would love to hear some more.

Mr Dalgleish—Again, thank you for the committee’s time and thank you for your interest in this issue. We believe it is a critical issue impacting on Australian youth.

[9.53 am]

BUGEJA, Ms Judith Anne, State Councillor, Queensland Alliance

CHEVERTON, Mr Jeffery, Chief Executive Officer, Queensland Alliance

GULLESTRUP, Mr Jorgen, Chief Executive Officer, OzHelp Queensland Ltd, Queensland Alliance

LAWSON, Ms Georgina, Sector Development Worker, Queensland Alliance

CHAIR—Welcome. Thank you for coming. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been given to you. We have your submission, and we also heard from OzHelp yesterday in Canberra as well. I would like to invite you to make an opening statement and then we will ask you some questions.

Mr Cheverton—I want to very briefly introduce the organisation, tell you a personal story and then just refer very briefly to our submission, which you all have. I understand that we will then have a fairly broad-ranging discussion. The Queensland Alliance is the peak body for the mental health community sector. We represent and support over 240 community organisations around Queensland that work in mental health. We promote the human rights of people with mental illness, we advocate for services that support people’s recovery in their own homes and communities and we also advocate for services that promote community well being and mental health. Some of our member organisations actually engage in mental health promotion and awareness raising, as well as responding directly to people with mental illness.

I want to tell you a personal story. I imagine you have already got a lot of these, but I guess I just want to honour the memory of a friend. I know Toni Anderson from ARAFMI has done a submission on her personal story. I would encourage you all, if you have not already read it, to read it. It is just heartbreaking. My story is about a friend and a flatmate, Katie, who took her own life in 1992. She was incredibly active in a whole range of areas. I knew her through my community work. She was involved with a range of women’s organisations and lesbian and gay organisations and also 4ZZZ radio. We had her 21st birthday, at which there were hundreds of people. She was incredibly well loved and incredibly well connected. We had all chipped in and bought her a pair of Doc Martens, as was the fashion at the time. So she had a brand new pair of Doc Martens. Five days later she was found in a car. She had gassed herself. She had gone into radio 4ZZZ and deleted every single piece of recording, and she had done an enormous amount of journalism over the last three or four years. She deleted her voice completely, so there was no record of Katie. None of us has a clue why that happened. She was only just coming out in terms of her own lesbian identity and she came from a very strongly Catholic family, but we do not know whether that really had anything to do with it or not. Certainly she had no mental health issues, no history of mental illness and no signs, as far as I knew from living with her, of any sorts of mental health problems, although I am not a clinician. All of that is to say that I know the tragedy that suicide can bring to families, to friends and to entire communities, as well as to emphasise, even though I am sitting here as an advocate for mental health services, that very often mental health is not actually at play.

Our submission is pretty brief. We have highlighted three things and I am happy to have a bit of a discussion with you. I can talk for ever, as a number of you already know, but I will not. I encourage you, if I could be so bold, to ask questions about our two members who are here and the services they provide and how they work in terms of suicide prevention. Georgina is here as the person who wrote the submission and can also contribute in terms of policy and information in relation to those points. Whether you want to go to services or whether you want to go to some of the other points we raise is up to you.

CHAIR—We want to go to both. Can we start asking you questions now?

Mr Cheverton—Yes, ask away.

Senator MOORE—I will go straight in. I expect everyone to have a go at this. It is about your first point—coordination. It is the bugbear of the sector and one of the things about which we are trying to see how government can move it forward. I would be interested in anyone having a go at that, particularly from the point of view of people who are acting now in agencies on the ground and from your perspective as a group that is already coordinating a number of smaller agencies across Queensland. How can we get that to work better nationally? I am also interested in your knowledge of the CSS in Melbourne, which is the information hub, we were told yesterday, and the links in research with Griffith University.

Ms Bugeja—As a service provider in frustration over our lack of ability to communicate effectively and in a similar pathway, we called together our local mental health services in a region based mental health collaborative that involved a whole range of non-government service providers sitting at a table with clinical services to try to make it as equitable as possible.

Senator MOORE—So that is around Highgate Hill?

Ms Bugeja—Yes.

Senator MOORE—Is that called Brisbane north, Brisbane central—Brisbane something?

Ms Bugeja—Metro south.

Senator MOORE—Is that under the boundaries of a state process?

Ms Bugeja—Yes.

Senator MOORE—So you pulled that together as the group working in that region.

Ms Bugeja—Yes. There is a lot of frustration about how you can interact with clinical services. It tends to be personality driven. We did not think that was a sustainable way to operate. It also provides us with an opportunity to get together as a sector and work in a partnership by identifying things that are of common interest to us.

Senator MOORE—And has that worked?

Ms Bugeja—So far, so good. It is very young; it was established in July 2008.

Senator MOORE—That is pretty good.

Ms Bugeja—We recently got some funding to support project work, so we are hoping it grows and gets stronger, becoming a larger voice.

Senator MOORE—I think that kind of local model is one that we are trying to look at. To the best of your knowledge, is that being replicated in any other areas of mental health across the state?

Ms Bugeja—Yes. Georgina probably would know more about that, having worked in sector development.

Ms Lawson—There are a number happening. The interesting thing with the south side group is that we have had co-engagement with Queensland Health at the beginning but it essentially has been facilitated by the non-government organisations. There has been a good partnership. In some areas we refer to the service integration care coordinators. They have been facilitators of some networks. That has worked in some regions—it works in the Sunshine Coast, and I think north Brisbane has a version of it—and there are some very good networks happening in Cairns and Townsville. They are all evolving in different ways, though, and some of them have been driven through the integration coordinators.

Senator BOYCE—What are the benefits of the service integration that you have seen so far?

Ms Lawson—The service integration care coordinators?

Senator BOYCE—For clients.

Ms Lawson—Some of the regions have care coordination panels that consist of people from non-government organisations and people from Queensland Health who collaborate on specific complex cases.

Senator MOORE—Does the Commonwealth get involved at all?

Ms Lawson—No.

Mr Cheverton—Ms Lawson is being slightly modest. Georgina is part of a team at the alliance that coordinates part of that activity, so part of her role has been to support the south side collaborative to come together. We have a similar worker based in Rockhampton who has done an enormous amount of work bringing organisations together. The real success of the Rockhampton model has been that Aboriginal and Torres Strait Islander organisations have been working directly with, for lack of a better word, mainstream community mental health organisations. We are now seeing much better links between social and emotional wellbeing and the more traditional mental health sector in that location.

There has also been work on the Sunshine Coast. You talked about the Gold Coast, and they have a very sophisticated sort of panel system, where people who have high needs are referred to this panel, depending on age range. All of the organisations basically put their hands up as to what they can provide, and together they respond to that group of people who have very high needs.

Townsville is another example of where there is a really strong community response. Three of the key agencies in Townsville have come together and formed a consortium and then negotiated with the public system to try to create pathways for people coming out of hospital and/or prevent them from going in.

A lot of the work of the team that Georgina is in is focused on trying to connect our members together but also connect into the public mental health system. What that means for a small number of people who access that sort of coordination, in terms of client outcomes, is that they do not have a fragmented experience and they do not have to trot around to six different locations. They can actually meet them—sometimes a bit like this, which can be a bit intimidating, as you can imagine, but it is a way of them connecting to a number of services all at once.

Senator MOORE—And the state government is working with that from the public health perspective? They are involved?

Mr Cheverton—The state government has funded positions.

Senator MOORE—Great. We have got the state government coming this afternoon, we hope, and we will ask them specifically about that.

Mr Cheverton—For us it is the Department of Communities, though; it is not Queensland Health that funds our activity in that area. In Queensland all of the non-government mental health is across to Communities.

Senator MOORE—Mr Gullestrup, is your industry based group linked into these kinds of networks?

Mr Gullestrup—Our experience is slightly different to that. The people we deal with generally do not have mental illness issues; they are generally going through a crisis. We are doing suicide prevention. When we deal with people it is generally at a time when they are suicidal at one level or another. Our role, I suppose, is really to try to keep them in the community and keep them safe for a period of time. But I have to admit that every attempt we have had at interacting with the public health system has been an absolute disaster. I would really have liked to have been able to come with a little sunshine story about somewhere where it worked well.

Senator BOYCE—What do you mean when you say ‘absolute disaster’? Can you give us an example?

Mr Gullestrup—I can certainly give you an example. There was one particular client we were working with over a period of time—a woman who had had a specific bad experience at a specific date and the anniversary was coming up and there was no real support network around her. Normally we try to hook into a family support network or something like that, but all her relationships were abusive. So out of desperation we simply tried to get her in somewhere just to get her looked after her for those days over that critical period. We rang three or four of the critical care units and were told that it was impossible and we had to take her through emergency.

At the end we took her to Ipswich Hospital, which sent us over to their acute care unit, which said, ‘They should know they shouldn’t send them over here,’ and sent us back to the Ipswich Hospital again. By that time we were several hours into it and the registrar nurse said, ‘So are you still suicidal?’ After six hours of waiting in an emergency ward, sitting there with sprained ankles being treated with more priority than her suicidal thoughts, she was absolutely exhausted. By the time she actually got to see the psychiatric registrar, she was just playing the game and wanted to get out of there. She later proceeded to attempt suicide, but by then we had a small chemist in our office, so she did not actually have enough drugs to complete it. That is one example we have had.

We have had another example where we had a fellow that was quite suicidal. We actually recovered a noose, a CD he had burned to play the music while he did it, a carton of beer and a packet of Stilnox from him one day and kept him safe for a period of time, but after sometime we said, ‘We can’t do this; we really have to take him to a hospital.’ We had Professor Graham Martin, who is a person we work with quite closely, ring ahead to the Gold Coast Hospital and say: ‘I know this agency and we work with them. They are coming with a client. Please receive this client.’ By the time we arrived there, the bureaucracy had gone to into it and our client had a seven- or eight-hour wait in the emergency department to be assessed, get a few tablets and be sent home again.

That fellow was all right. When he later contacted us again, what happened each time was that the relationship we had built up with that client was broken and we then had to go back and start re-establishing that relationship of trust again. Asking men to ask for help is not easy at the best of times. It is not an easy thing to convince a man: ‘You have to go to hospital. You have to get help for this.’ So, when he was suicidal again, we could not convince him to go to hospital. We rang the acute care team and said, ‘This is out of our hands; we cannot deal with it.’ They said they were too busy at the time to deal with it. Later they said they attempted to ring him, but we do not know that he made contact with them. He was found standing on a bridge a little later but was talked down and is still safe.

So the attempts we have made have been dealing with a medical model which is not prepared to accept that there are people in the community who are trying to do something. Our role is to not take people to hospital. Our objective—what we really try to do—is not to take them to a hospital, because they are much better cared for by family and friends if we can provide a safe environment for them. At our agency, we probably deal once a week with somebody who is suicidal. We have dealt with about 70 or 80 over the period we have been active in the industry, and over that period of time we have had to take five clients to a hospital, but none of them successfully.

CHAIR—There seems to be a disconnect between your experience with the public health system and a system that seems to recognise that providing mental health services is part of community services. You were saying earlier that you dealt with your funding through community services. There is a disconnect there. It is almost as if part of the system recognises that we need to be inclusive, look at social inclusion and deliver whole-of-community services yet, when it comes to the public health system, there seems not to be that recognition.

Senator BOYCE—BoysTown earlier talked about artificial silos. I suspect they are intentional silos.

CHAIR—Yes.

Mr Cheverton—The public mental health system has a different target group and simply does not have a lot of the time and resources to respond. The focus of the public mental health system is people who are acutely unwell. Someone who has not had any history of mental illness and is at the point of suicide is not really in the target group that they tend mostly to deal with. When you are under-resourced and you are in the hospital environment, you can adopt a fortress mentality; you can find ways to exclude people as a way of coping. What we think is really important—and I think it is increasingly recognised now—is that the resource solution to that is to invest in keeping people safe in their own homes and communities to stem the flow rather than having this notion that we need more hospital beds, which I think very few people now advocate.

CHAIR—We had put to us yesterday at our hearing in Canberra that there needs to be somewhere else to take people that are having an episode—

Mr Cheverton—Yes.

CHAIR—instead of taking them to emergency, which is not the proper environment to be dealing with the sorts of issues that need to be addressed.

Senator MOORE—Unless they have actually—

CHAIR—Yes, unless they have actually attempted. But if they—

Mr Cheverton—One of the things that we referred to on page 2 of our submission is the Time Out House initiative. That has only been funded by the Queensland Treasurer since the budget last year. The tender for that has just closed and the announcement is happening any minute. I was on the selection panel. That is about funding community organisations to offer safe, friendly and welcoming spaces. The whole purpose of that is an early intervention response, and the whole purpose of the place is that it is safe, friendly and welcoming—a mental health service that people actually want to access rather than one that you drag people to and that they then get a really bad experience of. We have a vision of how we want the system to be in 2020, and that sort of place is at the centre of our vision. We want those places in every suburb. We want them not to be stigmatised. We want the whole experience of people getting to a really high state of mental distress to mean that, instead of going to the shop and getting milk, they wander down to the little Time Out House around the corner and have a couple of days out in a safe, friendly, welcoming environment. That is what our vision is. Hospital services are still going to be important for people who are medically compromised and acutely unwell, but they will be a very small percentage of the population.

Senator BOYCE—You told a story where suicide and mental health were connected. This is a question I asked yesterday. All your submission is around improving mental health services as a way to assist in limiting the numbers of suicides. Can you connect those two things for me please?

Mr Cheverton—One thing is that we are talking about what we know about. While the first two dot points are about that, the third dot point is not. While we are talking about a mental health promotion strategy, that is not mental illness focused and it is for all of us. I think one of the most amazing things is that we are still only just talking about a mental health promotion strategy and we are not talking about it terribly much. We have referred in our submission to this discussion paper from Scotland, *Towards a mentally flourishing Scotland*. It is a fantastic, state-of-the-art, best mental health promotion policy you could find. We could rub out Scotland substitute Australia and give it to DOHA and that would be great!

Senator BOYCE—We can stop now can we, the inquiry is finished!

Mr Cheverton—That is right, here is the answer! There are six components to the strategy. One component is suicide prevention, one component is an anti-stigma campaign or a social inclusion campaign which you have recommended in here. On the way here in the car I said to Georgina: ‘What did they say about mental health promotion last time? We had better find out what they said.’ There is nothing about mental health promotion in here. When we focus on mental health services, we do focus still on the ambulance at the bottom of the cliff. Our argument is about having a mental health promotion strategy which is not mental illness specific—it is for all of us. VicHealth has a fantastic framework that is even Australian—it is not Scottish—that is a framework for mental health promotion. It is about building resilience, focusing on a flourishing community and increasing mental health. It might be a long bow but the other thing I wanted to bring to your attention was the Productivity Commission’s recent report on the contribution of the non-profit sector. It has this fabulous little diagram on how the non-government sector contributes to Australian society. It goes through inputs, outputs, outcomes and impacts. Basically, the Productivity Commission, which is the last place on earth that you would think would do this, has highlighted that the community sector’s key contribution is about community wellbeing and that the impacts of funding non-government services are, ‘a sense of self, safety from harm, engagement in meaningful activity, connectedness to others, ability to exert influence’.

That is essential to prevent people from taking their own lives. One of the questions I am often asked as a community advocate is: ‘Why does the non-government sector need to do this. Can’t the public sector do these sorts of things?’ The Productivity Commission has answered that for me. Funding non-government service delivery actually means you create somewhere where people can get a sense of identity, connection and purpose. That is intrinsic to being mentally healthy, to flourishing or to prevent suicide. There is the question as to whether you need to focus on suicide specifically—I think you probably do and there are things you can do specifically around suicide—but you actually have to keep your eye on the ball which is about wellbeing, connection and sense of purpose and that has to be a much broader strategy.

Mr Gullestrup—One of the things we find is that once we start talking about suicide, we end up talking about general mental health and wellbeing. Suicide becomes the thing that people are prepared to sharpen up on and focus on, but you cannot have that discussion without talking about general wellbeing and about dealing with issues and stuff like that at an earlier stage.

Senator FURNER—You mentioned that the single largest barrier in mental health and social inclusion is discrimination. Is that just focused on employment, or are there other forms of discrimination that you allude to?

Ms Bugeja—It is right across the board. Stigma is not just about broad community; it is about self-stigma. When people first come into the door in the centre at Brook Street, they I identify themselves as an illness. 'Hi, I've got schizophrenia and my name's John.' They are very focused on what their diagnosis term is and forget that there is a human being in there that is valuable and can contribute to a community. And in a very short period of time, those labels are gone and there is a connection and participation more broadly.

Senator FURNER—So there is stigma as opposed to discrimination?

Ms Bugeja—People are very cautious about who they disclose their mental health issues too. They feel that it will preclude them from employment possibilities across the board—where they live, a whole range of things.

Mr Cheverton—It is internalised discrimination. There are a lot of people with mental illness out there running the country, but they are not going to tell us. That is discrimination, that is stigma. Similarly, in business and with people who you are working with, as soon as you start going down that mental health path, men, and I think women as well, are just like, 'No way, I might be a bit odd, or I might be feeling down, but I'm not crazy!' It acts as a barrier to people seeking help and telling their wife, husband, friends, workmates.

Senator ADAMS—I am interested in the role of the internet and self-diagnosis. You mentioned the person coming in and saying, 'I've got schizophrenia'. Do you feel that a lot of people self-diagnose themselves by Googling and coming up with something and saying, 'Yeah, well that's me'? Do you find that with people coming into your clinic?

Ms Bugeja—In our community not everyone has internet skills or computer skills. People generally do not go searching for a diagnosis online because it is something that has been issued to them through the mental health system. It tends to have stuck with them. It may have changed, but they generally do not seek it.

Senator ADAMS—As far as clients coming in and the time that you can spend with them, as in weeks, could you give us an idea of how much time you are able to spend? Or do you have to take other clients and let people go before they are finally capable of looking after themselves again?

Ms Bugeja—Our focus is on connection and being part of the community. For some people that might take six months and then people are ready to move on and attend TAFE or go on to further study. Some people move on into the employment sector. For others it is a lot longer. So we do not have a time focus for people accessing our service. People can drop in; people can sit and wait until they are ready to participate in some of the groups that they are offered. It is self-determined.

Senator ADAMS—But there is no cut off, that is the main thing.

Ms Bugeja—Yes.

CHAIR—We have run out of time, as usual. Thank you very much. Your evidence is very much appreciated and hopefully we can do good things with it.

Proceedings suspended from 10.23 am to 10.36 am

PEARSE, Ms Carla Elizabeth, Chief Executive Officer, Community Action for the Prevention of Suicide Inc.

ANAND, Mr Peter Geoffrey Grant, President, Community Action for the Prevention of Suicide Inc.

BIRD, Mrs Dulcie Ann, Executive Officer, Dr Edward Koch Foundation

CAMP, Ms Myvanwyn, President, SOS Survivors of Suicide Bereavement Support Association Inc.

LARNEY, Mr Darrin, Executive Officer, SOS Survivors of Suicide Bereavement Support Association Inc.

CLARK, Mrs Fanita, Chief Executive Officer, White Wreath Association Ltd

NEAME, Mr Peter, Research and Publicity Officer, White Wreath Association Ltd

CHAIR—Welcome to this roundtable session. We thought it would be useful to have a number of groups together. In these sessions we tend to have almost a discussion not just question and answer. You will find that we will jump in and, if a question is directed to one of you but someone else feels like adding something, feel free to do that. I would like to welcome representatives of the White Wreath Association, Community Action for the Prevention of Suicide, SOS Survivors of Suicide Bereavement Support Association and the Dr Edward Koch Foundation.

I understand that each of you have been given information on parliament privilege and on the protection of witnesses and evidence. We have your various submissions. If any of you have an opening statement I invite you to make it and we will then ask questions. As I said, it will probably tend to be more of a discussion around various issues. I would like to tackle issue by issue. If we are on an issue and you feel like you want to add to it, we will do that and then move onto the next one.

Mrs Clark—Thank you for involving the White Wreath Association in this inquiry. I will briefly go into my background. I am CEO and founder of the White Wreath Association action against suicide. It was founded because of my personal tragedy. My only son was diagnosed with schizophrenia, paranoia and severe depression shortly before he took his life by laying himself on a train track. I also feel that the following points in my life are relevant. Shortly before our son took his life, my father died of cancer, then our son tragically took his life. Shortly after, within about six months, my mother-in-law died of cancer, then my father-in-law died of cancer six months later and then, shortly after that, my brother-in-law died of an aneurism. I saw firsthand how the medical profession and emergency services treated those people that had these other life-threatening illnesses compared to somebody who has and was diagnosed with mental illness.

One thing sticks in my mind: when I called the ambulance for my son, I remember the ambulance driver walking into my home saying ‘What a stupid idiot, you are. What have you done to yourself?’ At the time he took an overdose of prescribed medication, which did not work, and he tried to connect the hose to the exhaust pipe of his car, which did not work. The ambulance officer came in with no compassion, no understanding not only for what our son had done but also for me because I was in a terrible frame of mind about what had happened.

Another thing has always stayed in my mind: I was with my father, my mother-in-law and father-in-law. I was the only visitor when the treating doctor or the specialist came down and said to these three people, who were direct family members, ‘I’m afraid I have bad news for you. You only have weeks or months to live. Your illness is not curable; it is terminal.’ At no stage did that specialist ask who I was, what I was, ask me to leave the room or ask the patient, ‘Do you want this person in the room with you’; they just blabbed the information that they gave them.

Our point of concern as the White Wreath Association is the difference in understanding and compassion but, most importantly, the involvement of the family. I know for a fact that with any other life-threatening illness the whole of the family is involved because I experienced that firsthand with all the deaths that we had prior and after the death of our son. The medical profession and the emergency teams included the whole family every step of the way with help and treatment. They know full well the most important help, apart from the medical profession, is the family unit, family support.

My points of concern are: (1) if it is agreed that suicide is life threatening then the question arises: why don’t these people receive the sort of speedy emergency services help that anyone else would receive with a life-threatening disorder? For example, heart attacks, stroke or serious injury. (2) What other life-threatening and emergency is subject to delay? (3) Confidentiality and privacy must not be allowed to cause loss of life. Commonsense, natural justice and good professional practice dictate that the preservation of life is of paramount consideration. Doctors and psychiatrists must involve families and use their knowledge and opinion to help fight this epidemic as they would with any other life-threatening condition. (4) Why are people who attempt suicide released almost immediately only to complete the job a short time later? Our own research—that is the White Wreath Association’s research—from the letters and emails et cetera that we receive indicate that in most cases these people do suicide. They are discharged too early or refused treatment altogether. The key question that has been ignored is: what happens when a suicidal, mentally ill person, a friend or a loved one first presents for help? We know from our research that these people are routinely turned away, and this is where early intervention should be occurring.

We receive many emails. As recently as last Friday we received an email from a person who presented to emergency in a public hospital where she was sitting in a pool of blood for quite a long time before anything was done for her. Would you like me to present it here or leave it here for you?

CHAIR—If you could table it.

Mrs Clark—All right. Hopefully you take our points of view and our opinions to be of the utmost importance.

CHAIR—Thank you. And please believe that we do.

Mr Neame—Thank you for the opportunity to speak. I am a forensic nurse and mental health nurse of 39 years. I will speak very bluntly and to the point. I notice that six of the panel are female. In relation to mental illness and suicide in particular, men are four times more likely to commit suicide and nine times more likely to commit murder. Over the years I have represented families in New Zealand and Australia. My particular concern is that suicide is a diversionary, fiddling while Rome burns thing for parliaments, from the most senior person. Although, when Fanita first had the White Wreath Day in Canberra, John Howard was there and so was Kim Beazley.

Most people do not understand how violence, suicide and murder are connected and if you prevent one, you prevent the others. There is a lot of nonsense talked about suicide. You are welcome to disagree with anything I have said. It is very blunt and to the point. Most of what your committees have produced over the last 15 years is absolute nonsense. You need to get to the point. You need to pick up what Fanita said about first-line prevention. If a person presents you do not turn them away. That might be the only opportunity you have got to save their life. As I said, as I look around the committee here, suicide prevention is not about nurturing. It is about understanding the neurological basis for mental illness. You and I are not programmed to kill. The person who is suicidal is neurologically programmed to kill, so you have to intervene early and, if you do not, you will have a death on your hands. I go back to the first point: six females. In other words, less than 17 per cent of the panel are males, and males are four times more likely to commit suicide and nine times more likely to commit murder.

CHAIR—Thank you.

Mr Anand—I might give you a short introduction on CAPS and ask Carla to add to that. CAPS was formed about nine years ago. Similar to what we have just heard it was formed by a number of individuals who had been touched by suicide, usually by bereavement, and wanted to do something to stop that from happening to others. They felt in their various ways that possibly what had happened to them could have been prevented. I became involved later, not in that way. I am a trustee director of a large super fund which has over a million members. We lose about 15 of those a month to suicide. You see it happening month after month.

Senator FURNER—Which fund?

Mr Anand—Sunsuper. I am not speaking on Sunsuper’s behalf, but that was the way I became involved. You feel that you want to try to do something as well. Carla is different again. She has over 30 years experience in suicide prevention as a counsellor, a manager of Lifeline and a telephone counsellor. She has been acting as an executive for CAPS. CAPS began by funding academic research and then felt that they wanted to do something more active as a service model and funded an inquiry by Carla into what gaps people involved with suicide felt existed in the environment around people at risk, and identified two key gaps. One was information and the other was the need for an intensive, nonclinical social support. They found that the medical and social services which are rationed are not able to allocate the amount of time needed to help individuals live through difficult times and also that families and carers of those people can become much more effective in their role if they have intensive counselling and practical support. So I will just ask Carla to elaborate on the model that she has been operating now for a couple of years.

Ms Pearse—I guess the thing that came out of the needs analysis that I did—I agree with Fanita—was that currently the mental health services do not provide adequate support for somebody at risk of suicide. Family and friends of somebody at risk of suicide have almost nowhere that they can go to to get some assistance to try to understand the issue a little better. So my experience over the last couple of years—and I can only speak from my experience of the people I have been working with—in working directly with people at risk and working directly with their families and friends is that the key is intensive one-on-one support for a period of time. During the course of that intensive support you provide information and you simply provide time for them. I am a therapist by trade but I do not do therapy per se; I use therapeutic techniques and I provide tools and techniques for them to learn to manage whatever pain and suffering it is that they are experiencing.

In addition to that, one of the main things we do is work with family and friends. We have discovered that a lot of the pressure that a lot of suicidal people feel—and again I can only speak from my experience with the clients I have worked with—comes from their families and friends. Their families and friends do not mean to put pressure on but they are so desperately keen for them to not feel this way that they often respond and react in a way that is not terribly helpful. That just makes the suicidal person feel more overwhelmed and more at pressure. So my task, as I see it—it is how I have been working for the last two years—is to try and relieve the pressure on the suicidal person, which is why we work with the families and friends. So we give them information as well—tools and techniques—and help them understand the issue better.

Sometimes we work with the whole family. Sometimes I work purely with the family and I do not work with the person at risk at all if the person at risk does not want to talk to me. Sometimes I work with them separately. Sometimes I work purely with the person at risk and do not connect with the family. My experience, as well, is that a significant proportion of the people I work with are under the care of psychiatric and/or psychological help, and that is not helping. It is simply not providing the right sort of response for them.

I am afraid that I do not quite agree with Peter, in that what I do is provide what the community may have provided 20 or 30 years ago—what families, friends, relatives and community connections would have provided. What I do is not particularly complex at all. I give them time, care and attention. I give them skills and tools and I help them understand their thought processes. It seems to work.

If they require mental health intervention then we encourage them to seek that. We help them to do that if they need it. I never diagnose—I am not a mental health specialist—but I see a number of people who are already under psychiatric care who it is simply not happening for. They feel no different from the time they first started seeking psychiatric attention to when they come to me.

Mr Anand—And we do sometimes get people referred by psychologists and psychiatrists.

Ms Pearse—Yes, absolutely. That is where CAPS comes from. We try and work in a very holistic way. We encourage multidisciplinary support if that is what they need. It is a very client centred approach. We provide whatever it is that the client needs to reduce the pressure—to give them the space to be able to look at their situation more clearly and more effectively—and then work on whatever the issues are that are bringing them to this point of using suicide as an option to solve whatever issues are there for them.

It is intensive. For some clients I can spend a number of hours a day for a few days in a row possibly. It is a very intensive model but what we have discovered, as well, is that generally that is short term. You give them the intensive support for a short period of time so that they can start getting some perspective back again. Then we can start reducing the time and refer them out, maybe, to therapists or psychologists who are comfortable working with suicidal people. That is our experience.

Mr Anand—If I may add one thing to that to round it out, CAPS is limited financially so currently our service consists of Carla on a part-time basis. We are seeking funds primarily from the state government and our aim is to be able to employ two full-time counsellors who would support each other and would provide this service and would also train a group of volunteers who would provide supplementary social support of this kind. We would test that model and formally evaluate it with a view that that model could then be reproduced around the country. That is the idea.

Ms Clark—Chair, are we allowed to comment on what they have said or do we wait until later?

CHAIR—If you would save it because I think it would all start getting a bit confusing. We will finish the opening statements and then we will get into some of the discussions.

Ms Camp—Darrin is going to give our introduction. Initially I was not supportive of this inquiry because I thought what a waste of money as we have gone through this suicide thing so many times and the mental health inquiry and the men's health inquiry and forgotten children et cetera. But then I realised, and this is really important because it applies to all of us plus those who are suicidal and those who are looking after them, that if one knows no better and if one cannot do any better by our being here we are educating ourselves. Also, what Carla is doing is helping people educate themselves about their emotions. She is helping to educate the families as to how to cope with someone who has these feelings. Yes, I do agree with Peter that there is a neurological side. He spoke earlier about foetal alcohol syndrome, and certainly I think that is a big factor in some communities.

Mr Larney—Suffice to say that there is in some cases a neurological factor and in a lot of other cases there is not or there is no determined or predetermined neurological factor. I suppose what we are saying is that the vast majority of those who have successfully completed suicides in Australia have not come from the mental health profession. They have not been diagnosed as people who were mentally ill. A classic example is my own experience, but before I actually get into that I will give you a little bit of a rundown on who SOS is and how we work.

We were founded in 1997 so this year we have been going for 13 years. We were officially incorporated in 1998 and we have been offering support services to the bereaved through suicide ever since. The organisation was founded out of a chronic need for peer support within the community. I suppose the hardest issues that people who are bereaved through suicide have to face is social isolation. The whole concept of suicide has always been, and I suppose for a long time it will remain so, a taboo subject. It has a vast stigma attached to it and because of that it is a hidden problem; it is a hidden grief. You do not want anybody to know your dirty laundry so it is very much a closed set. People do not understand how to relate to you and how to communicate with you and how to talk to you. There is always that ‘aren’t you over it yet?’

Grief, particularly suicide grief, is a fickle animal. There is no time frame to it. The old expression that time heals is unfortunately reversed. It should be healing takes time. It depends on the type of grief that you are suffering. Obviously, the amount of support that you are getting will determine likewise how long it will take for somebody to recover from their grief or to learn to deal with it or to learn to live with it. As for my situation, I lost my partner to suicide in 1999. He was not diagnosed with any mental illness. It was not apparent that he had any particular mental illness. He simply had life issues and situational depression set in. He floundered through a sense of hopelessness over the situation that he was in and ultimately he decided to take his own life. I was the one who found him.

Unfortunately, I cannot agree with some of the things that have been said here today. In my circumstance the medical profession was fantastic. It is unfortunate that we are all going to have different experiences. It depends sometimes on the individuals who are involved, as opposed to the profession as a whole. The reality is that the depression that I went into, the grief road that I went on, and the sense of helplessness because of my situation led me to attempt suicide twice. I was fortunate in the respect that I had a very understanding, very loving and very supportive family—even though I could not talk to them. It is often the ones who are closest to you whom you cannot tell how you feel. You cannot be entirely honest with them because you do not want to hurt them and you do not want to upset them. You want to protect them from what you are going through.

The end result is of course that I am still here. It was through my introduction to SOS that I discovered that I was not the only one in the world to be going through what I was going through. It is a very isolationist experience because, again, people do not understand what you are going through; they do not understand what you need. You need to be able to talk to somebody who knows what you have been going, who knows what you have experienced. So it was only through peer support that I was able to climb out of the hole that I was in. Was I mentally ill? No, of course I wasn’t. I was depressed through grief. I did not fit into a mental health model. When I spoke to my doctor all they wanted to do was medicate me. How was that going to help me to travel my grief road and to work through the demons that I had to work through to get over my grief? Sometimes medication is not the answer. I think you will find that one of the greatest temptations of the medical fraternity is to medicate symptoms away rather than deal with the actual issues. I am not saying that peer support is the answer to everything. Of course it is not, and certainly in cases where mental illness is a factor there need to be appropriately trained medical practitioners involved. Even in situations where maybe situational grief is particularly pronounced, likewise there needs to be medical intervention. I am not knocking the medical fraternity. I am just saying that sometimes they are too eager to provide medication as an answer.

As far as the actual strategy itself is concerned, one of the things that we have certainly experienced is that somebody who is bereaved through suicide is up to 10 times more likely to be suicidal themselves and have suicidal indications. I do not think there has been anywhere near enough emphasis on postvention as a factor in providing prevention in the longer term. Likewise there has not been enough emphasis on social support and on building community resilience. A lot of the problems that we face are through stigma, the stigma of somebody who has had a suicide indication or has perhaps attempted suicide or of somebody who is mentally ill. We need to break down the barriers so that the community will get involved, so that it will start taking an interest or offer its support or its help. Breaking down the barriers will by definition reduce the rate of suicide in Australia. By removing that stigma we will also reduce the amount of retraumatisation. Another significant problem for survivors is retraumatisation through the stigma that they suffer because of the fact that they have lost someone to suicide or they have had suicide indications themselves. Have I missed anything? I think I have pretty well covered everything.

Senator BOYCE—Who funds SOS?

Mr Larney—No-one—sausage sizzles and raffles. We have had a number of very successful campaigns. We did a regional tour through Queensland a few years ago whereby we were able to get some funding from the gambling benefit fund in Queensland. But basically everything that we do is self-funded. From the point of view of the organisation itself, we offer support groups in Cairns, Bundaberg, Gladstone, Hervey Bay and Brisbane. Previously we have also offered one-on-one counselling support. We have a professional counsellor who is a member. In addition we have an extensive referral network to other councillors, psychologists and psychiatrists where the need arises. We offer a 24-hour, seven days a week phone service offering support to those who are at risk and those who are bereaved through suicide. We offer a bimonthly newsletter and we have a range of publications that we distribute. Every cent that we spend is raised from the community and from within our own organisation.

Mrs Bird—Thank you for giving me the opportunity to speak here today. The Dr Edward Koch Foundation is not as well known as some of these organisations along the table, but we were set up 14 years ago to help with public health issues. Whilst we do many projects of a variety of types, suicide has become our main focus because of the alarming rates of suicide in North Queensland. We are not funded by the government. We are self-funded but we have managed to do a lot of good work in North Queensland, especially in Indigenous communities, over the last 14 years.

Our main focus is our life program, which incorporates the life suicide prevention workshops, the life bereavement support service and the Far North Queensland suicide prevention task force. The program has developed over many years and has its roots in the Far North Queensland Suicide Prevention Taskforce. That was set up in the same year as the foundation and it now consists of over 120 agencies all working towards suicide prevention. Of course SOSBSA in Cairns is one of our partners in the role of trying to work collaboratively to identify gaps in the community, and we have over the years identified many things that have been lacking. As a result we have developed flow charts for all the communities of Far North Queensland. These flow charts are a guide for people who are helping people at risk. They have the emergency numbers on them, as well as the 24-hour numbers and the questions to ask. These flow charts have been developed in every community, and we now get asked from all over Australia whether people can adapt them to their communities. Other things that we have developed are brochures on suicide and self-harm. We have brochures for Indigenous people and for culturally and linguistically diverse people because in Cairns there are 72 different groups in the CALD area.

From the task force the life workshops have grown. There was also a need to educate communities about suicide prevention, so our workshop, which was developed in conjunction with Queensland Health and the Department of Communities after Cyclone Larry, has developed to something even better, where whole communities get educated on suicide prevention. It was designed so that not just health professionals but people like the butcher or someone dealing with the public can do an intervention. The man at the bowser might pick up on something that someone says.

The life bereavement service is the other thing that we do in the life program. We assist families, police and ambulance at the time of the suicide. This service is provided by counsellors who are fully trained to help people cope with death and trauma. It offers phone and face-to-face bereavement counselling. The life bereavement service has a memorandum of understanding signed with the Queensland Police Service. It incorporates a faxback referral system, which requires that a Queensland police officer who is attending any unexpected death offers the support of our life bereavement support service to the person bereaved. A person agreeing to this signs the faxback referral assistance request, the police officer faxes it to us and we are able to go out and see these people. This is a new initiative in Queensland and, as well as helping the families, many other positive outcomes are being derived because monitoring of suicide incidents in the region is being done now through the faxback referral systems.

We have been putting our workshops around the communities. Last year we did 11 Indigenous communities try to train communities in our suicide prevention workshops and we work closely with the Queensland Police Service doing that and the Cape PCYC. They have been so successful up there that this year we are working in just the NPA area. I heard you ask a question earlier today about Torres Strait Islanders and Aboriginals, and, yes, we do have that problem, especially in NPA where there are five communities—two are Aboriginal and three are Torres Islanders—and none of them mix at all, but we are gradually educating them that, in the case of suicide prevention, we all have to work together as a whole to achieve something.

The other figure that you mentioned is that 10 people are usually affected by a suicide. We have found that that figure is a load of nonsense—whole communities are affected. We had a 16-year-old boy suicide in Kuranda. We did 43 face-to-face interventions for that one suicide. In a small, remote town in Queensland there was a public hanging in the street on a Thursday and, the day after, a boy lit himself with petrol. Two suicides in a small country town are too much for a town to bear. They rang us and asked us to come and help. It was out of our area—it was a nine-hour drive from Cairns—but we went because you cannot leave people to flounder when they need help.

Senator MOORE—Where was that?

Mrs Bird—It was Hughenden. I will stop there. I have heaps to say but I had better stop.

CHAIR—I am sure you will get another opportunity through questions. Mrs Clark, you wanted to say something earlier.

Mrs Clark—When I wanted to answer was when I listened to CAPS, but now, after listening to everybody, my question is: what happens when a suicidal, mentally-ill person, their friend or loved one, first presents for help—what happens? Our organisation knows that there is nothing forthcoming. There are no services, there is no help—not only to help the sufferer, the victim, but also the family that is in such a dilemma that they do not know what to do. Who helps? Where? Confidentiality and privacy laws say that you cannot intervene. I would like Peter to collaborate on what I am saying.

Mr Neame—Just to back up Fanina, I have been a mental health nurse for 39 years but I am also a general nurse. I have been out on ambulance calls. I started working in hospitals when I was 14, as a cleaner. So there is very little that anyone, whether it is a professor of forensics or psychiatry, can tell me about mental health. I have spoken at international conferences on the same subject. You mentioned education; you mentioned coordination—they are the great things that have been talked about. They are nonsense—they are utter nonsense. They rely on rational behaviour. Suicide is not rational behaviour. My generation, the post-war baby boomers, said suicide is the ultimate choice. That pollutes the thinking of suicide prevention. It pollutes your thinking, it pollutes my thinking. Durkhein was totally and utterly wrong. Every living thing strives for life. If you have problems in your limbic system, where the life force is or survival instincts are, which is classic of any mental illness, then you can be programmed to suicide, kill or be violent. George Bush had a seminar on school massacres and the FBI studies were on millions and millions of people. They said that 81 per cent of these people give a warning. In other words, 81 per cent of current suicide is preventable. They also said that suicide and murder are two sides of the same coin. So it is not a dream that I have, it is not a personal obsession I have; it is a fact.

I have lived long enough to see the closure of mental hospitals. With the closure of mental hospitals in Australia—Senator Mark Turner, are you listening—the suicide rate in young men has gone up 400 per cent and in New Zealand it went up 600 per cent. So I get a little bit irritated with nonsense. Politicians have had this subject for the best part of 40 years and nothing has changed. The suicide rate has come down marginally, but, if you listened to Fanina carefully, a lot of coroners will not record suicide; they call it ‘accidental death’. So the suicide rate in fact is four times the official statistic. Some people would say it is eight times the official statistic. A lot of head-on collisions on open roads, for example, are deliberate murder-suicide attempts.

Mrs Clark—The White Wreath Association estimates over 8,000 a year in Australia every year.

Senator FURNER—How do you establish that?

Mr Neame—I wish I knew you were going to ask me that, because I have just read the *New Zealander* and there is a case of a person on trial who tried to commit suicide. He killed a woman and a child and injured another person, putting him off work forever. He is still alive. That is three people by one person’s action. If you see our suicide guidelines on our website you will see three or four cases—two from Queensland, one from New South Wales—where a young family man presented for help. They turned him away, so he went home, killed his whole family and then killed himself. Of course, I am a forensic nurse; you have to remember I look after people whose primary thing is crime, particularly murder. I have looked after at least three truck drivers who have driven into other traffic and injured, maimed or killed people. So how do I establish it? I know from hard, factual evidence.

If you ask police privately, they will tell you the same thing, and police are the front-line mental health workers. There is nobody else—there is nobody in this room—who are front-line mental health workers. My neighbour was suicidal. I called the police. They said, ‘We’ll take him to outpatients, but the chances are he’ll be home within half an hour.’ He was home within three-quarters of an hour. That is the system at the moment. That is why I am not particularly forgiving in what I say.

CHAIR—Ms Clark, when you said that there is no-one to go to and no service available, you are talking about through the public system such as when you turn up at hospital?

Mrs Clark—Yes, I do talk about the public health system, but our organisation has also experienced many who go through the private system, where they want to make an appointment with their psychiatrist and it can be three, four or six months that they wait to see one. What is the point in that? Tomorrow they could kill themselves. They are making the effort of seeking professional help, but the professional help is not there. I think there is a lot to be looked into about what is available. Though I have heard from other groups explanations of what the organisations do, the White Wreath Association did not put in their submission. I do not think that we have to explain what our organisation does; hopefully, all the senators here today know what we do and how hard we have been working to combat this epidemic.

Senator MOORE—Consistently through the evidence and submissions we have received, people raise the issue of coordination of services: when people present then there are a range of organisations and services that are working in the area, and it seems to be difficult for anyone to find where they are being coordinated. Ms Bird, my understanding is that the PCYC program you are talking about is one of the things being funded by the federal government. Senator Furner has been helping me. We had their evidence yesterday, and they listed so many things that they are funding. I wanted to clarify that that was the program that you described in North Queensland.

Mrs Bird—Yes.

Senator MOORE—Post Larry, there was a real focus on the north and on how we could get mental health programs there for the community to access. I am interested, though, in the task force to which you referred. That was a state government program? Is the state government involved?

Mrs Bird—They are members of the task force—

Senator MOORE—Fabulous. That is what I want.

Mrs Bird—but the task force was set up by the Koch Foundation. It is a non-government task force.

Senator MOORE—And this based in Cairns?

Mrs Bird—Yes.

Senator MOORE—So there has been a genuine effort somewhere to list all of the services that are available in the region.

Mrs Bird—Yes.

Senator MOORE—And those services are able to share knowledge?

Mrs Bird—Yes—and we do.

Senator MOORE—So can a person or family that could be trying to work through these kinds of issues—they are very personal but also have some general aspects to them—access your task force directly or is this something that is done to share knowledge between organisations?

Mrs Bird—We share our knowledge. For example, if someone did ring the task force, the task force does not counsel but we would immediately tell them about Lifeline and the Hopeline and Centrecare and Anglicare and all of those other agencies, because all of those are members of the task force. So we are very aware of every organisation. Queensland Education is a member, and so is QAS, the ambulance service. Out of the 120 agencies, all are involved. Just prior to Christmas I sent out an email asking all members whether they still wanted to be active. I accidentally sent some emails to people that I thought were local organisations. They were Brisbane Indigenous organisations and they have actually come on board on our task force up north.

Senator MOORE—In terms of maintaining it—and one of the things to effectively coordinate is to keep it up to date and keep people engaged—is that a task that is allocated and funded?

Mrs Bird—We have never been funded. It just works because we are all volunteers and we work very hard.

Senator MOORE—It could all fall over at any moment because—

Mrs Bird—It has been going for 14 years and it is not going to fail. We would love government funding of course, but we are not going to stop it just because we have not—

Senator MOORE—Is that volunteer engagement? That is a core aspect. It is the difference between reliance on volunteers who give so much through commitment and passion but then burn out, as happens, and also move.

Mrs Bird—The Koch foundation, of which I am also a founding director, has given a commitment that they will ensure that the task force continues. One of the things that we have achieved through this great mass of volunteer support is the Queensland Suicide and Self-Harm Prevention Conference in 2008. We received $40,000 in sponsorship from Queensland Health and that helped us with the conference. We put on a very good conference with 300 delegates coming, and of the 96 presenters, 31 were Indigenous, which is really fantastic.

Senator MOORE—In terms of a request for funding, what would be the basis of that? Give us your pitch. Why do you think that funding would be an appropriate aspect to maintain the services? Why do you think it would work?

Mrs Bird—We work such long, long hours. It is nothing for me to work through the night. I would really love to have an assistant or someone that could just help with some of the work, for example, the flowcharts. To put flowcharts in every community in North Queensland costs us so much money in printing costs and so forth, and we try to make sure that they are completely up to date by checking every three months with each community that the numbers still exist. We do that by holding a community workshop and then the participants will often point out any numbers we have got wrong.

Senator MOORE—And following up the issue of your workshops, are the workshops similar to those run by Lifeline and the Mental Health Council? We seem to have the product but I am never quite sure whether they are being customised, as they need to be to meet local arrangements—

Mrs Bird—Ours are customised.

Senator MOORE—So you have taken a model that is pre-existing—

Mrs Bird—Yes, and we have worked on it to cater for the more basic level of person that might want to know the warning signs to look for and ways of responding to those warning signs, and also what resources are available—and by that I can say, for example, static and dynamic risk factors. If we were working in an Indigenous community we do not use the word ‘static’; we would say ‘things that you cannot change’. The literature has been focused on people who are not very literate—

Senator MOORE—But they are the Lifeline model—

Mrs Bird—No, I would not say that it is the Lifeline model. We developed it from our findings from the task force.

Senator MOORE—That is the same title as the Lifeline products.

Mrs Bird—No, it is not—

Senator MOORE—Can I ask all of you about your link with Lifeline. The submission we received from Lifeline picked up many of the issues you are raising but I think they have the view that they already have the capacity or the basic model to link in with people and families. If you read their submission you will be able to see the claims they have made. Do you have links with them in terms of the services they provide?

Mrs Clark—I know the White Wreath Association was on their books. We are completely and totally voluntary; we do not receive any government financial assistance but we were getting calls at two and three o’clock in the morning. All of these people ringing at that time of the morning were saying that Lifeline had referred them. So eventually, as head of the organisation, I rang Lifeline and said, ‘This is your job; you’re supposed to sort it out. Why are you referring these people?' They were referring those people because they were in the too-hard basket. They were people who were constantly ringing them—nuisance callers, more or less—and Lifeline were fobbing them off to whomever. They fobbed them off to us.

Senator BOYCE—There is another agreeing down this end.

Mrs Clark—They fobbed them off to us and I said, 'No, that's not good enough.'

Senator MOORE—Without discussion?

Mrs Clark—Without a discussion. This networking business was one sided. This networking was: 'Okay, let's network. We'll refer patients.' But they were referring clients who were nuisance callers. So we put a stop to that.

Senator MOORE—That was in White Wreath?

Mrs Clark—That was in White Wreath. Eventually I had to put a stop to the phone numbers that were coming through because they were nuisance callers constantly calling. So our experience in that respect is, 'No, you're getting the government funding; you do your job.' That is what they are paid to do. Okay, we are here, but on a different level. If they want to discuss this; let's discuss it, but there was no discussion. I even rang and spoke to the CEO, who did not want to speak to me.

Ms Pearse—I just want to speak in defence of Lifeline, because I was a general manager of a Lifeline centre for nearly seven years. In terms of telephone counselling they have limitations, and now that they are on a national service it is probably easier to work with some of these people. When they were going to their local centres it would be frustrating for telephone counsellors to have the same person ring up with the same issues time and time again.

CHAIR—You think it would be better now that they are dealt with nationally.

Ms Pearse—Absolutely. I think there is probably a better response. This is just my view. They may not agree but I think that it would probably be a better response. In terms of face-to-face counselling, they are no different to any other service. They have absolute limitations on how they can respond to somebody who might want one-to-one, face-to-face counselling. It is still an hour appointment once a week, once a fortnight or once a month. So Lifeline has no option, sometimes, but to refer elsewhere. They have limitations in their capacity to respond. I guess that is partly what CAPS came out of—knowing what the models in many of the organisations are like. That is why we do it differently.

Mr Neame—There is something I would like to add to that. I have worked in the mental health service for 39 years. When I started there were three or four patients, in a hospital of 450 patients, who were committed for life because they had repeatedly tried suicide. Now what happens is that they are released to finish the job. That is the problem. Talk therapy, education, coordination—they are hoary old arguments that have been around for over 40 years. They do not make any difference whatsoever. The word is based on the Latin 'sui' for self and 'caedere' to kill—self murder.

The Muslim religion and the Catholic religion outlaw suicide—not for voodoo reasons but because they want to drive those people; they want to give them a conscience, which they have not got, and drive them to treatment. If you do not understand how serious suicide is the whole thing is a waste of time. I have read literally thousands of reports on suicide—probably more than anyone in this room—and most of them come from the point of view of a social course saying, ‘If we teach these people the error of their ways they won’t try it again.’ That is absolute nonsense. It is utter and complete nonsense.

If you do not understand suicide you will not understand that when they first present, or when their family first asks for help, that is when you have got to help them. If you do not help them then you will lose a considerable number of people. As I said, since the closure of hospital beds—there were 300 beds per 100,000 population throughout the world—there are now fewer than 30 and they are all acute beds, short-stay bed. If you do not help those people when they first present you will have a higher rate, which we do have, and so does New Zealand.

CHAIR—Now, in terms of the Lifeline question, I saw that you reacted a bit when I asked about it.

Ms Camp—We do get the nuisance callers but I think they come from everywhere, because they seem to have a very good knowledge of how to use the system.

Senator BOYCE—When you have worn out your welcome with one service, you go to the next one.

CHAIR—Can you define ‘nuisance callers’ for us?

Mr Larney—Some of them are, shall we say, obscene.

Ms Camp—They are looking for sexual satisfaction. That is not something that we can provide them with.

Mr Larney—Aside from that aspect, we do also have a number of ‘frequent fliers’, as we call them, purely because they just need someone to talk to. Those people generally are in the mental health system—they have case workers, they have psychologists or psychiatrists, who, at two o’clock in the morning, do not want to talk to them—understandably.

Ms Camp—And they are very lonely.

Mr Larney—And they are medicated, so they are quite safe. But they are very lonely. They just want someone to talk to. They cannot sleep.

CHAIR—I do not know about other politicians, but certainly my office has regular people that call us up for the same thing.

Mr Larney—Strictly on the Lifeline question, I would not say we have close links to Lifeline—we exchange information, we exchange numbers and what have you—but we do receive quite a significant number of referrals from Lifeline. But we receive a significant number of referrals from all sorts of agencies—from the Salvation Army, from the mental health system—

Ms Camp—People looking for bereavement support.

Mr Larney—from police, from ambulance.

Senator BOYCE—Lifeline, in their submission, suggest that there should be a mandated emergency number for suicides, like the 000 number. Could I have the view of the panel on that topic, please?

Mrs Bird—I work closely with Lifeline on a lot of issues up in North Queensland, so I do support them. I insist that my counsellors have the ASIST training. But I do know that we get calls—not just nuisance calls—from people who do not want to ring Lifeline, for the very fact that it is not personal enough, it is too big, it is national. You might get someone down in Woop Woop somewhere.

Senator BOYCE—Who does not have a clue about your town.

Mrs Bird—Yes. They want to talk to someone locally.

Senator FURNER—Are those calls from remote Aboriginal communities?

Mrs Bird—No. I am talking about callers in Cairns when I say that. We do not actually counsel people who are suicidal; that is Lifeline’s job in Cairns. We are for people who have been bereaved. But we get those other ones and we do not turn them away, of course, when they say, ‘But we don’t want to ring Lifeline because’—

Mr Larney—Quite often the biggest problem that we have is not so much that they do not necessarily want to ring Lifeline but perhaps they have tried several times and not been able to get through. The demand on Lifeline, Kids Helpline, MensLine and all of the services that are currently in place is huge. They do not necessarily have the facilities or perhaps the infrastructure to be able to cope with the number of calls that they are getting. So we by default get a significant amount of the overflow.

Ms Camp—In section 6 of our submission we have actually suggested a dedicated national suicide crisis and follow-up line—which I notice that the Suicide Call Back Service now provides. I have taken calls from people, particularly in the central highlands area, who have been very appreciative to know that the Suicide Call Back Service does provide the six free counselling sessions over the phone, because they do not want to go and see their doctor because it is a small community—they might even play golf with the doctor, and they do not want the doctor’s assistants knowing about their problems, because they suspect that maybe the doctors’ assistants would know. So they are very protective of their privacy.

While we might say, ‘Let’s get rid of the stigma,’ at the moment the case is that they are very protective of their privacy, so we have to work on that basis. So, when I tell the young fellows, ‘Yes, you can get this free counselling over the phone,’ they are often really quite grateful. They are very confused about the way they are feeling and they will not talk to their mates about it.

They will say things like: ‘I’m just sad. I’m not mad. I’m not depressed. I’m just sad.’ We then have to work them through understanding the process of depression, if it sounds as though they might have depression. We cannot diagnose that, of course. But I do refer them to the Black Dog Institute, which has a self-diagnosis kit and say, ‘Fill that out and take it to your doctor.’

The other thing is well-known, that a lot of people do go to their general practitioner within four weeks prior to their suicide but they say nothing because they are hoping, I assume, that the doctor will pick something up. But how do you pick something up if you are not told. So you have got all those issues.

CHAIR—If your family do not pick it up—

Ms Camp—Yes. So once again you get back to if you know no better, you cannot do any better.

Ms Pearse—I have a great deal of respect for telephone counselling services. I think they are brilliant and I do refer some of the people that I work with, between midnight and dawn pleases ring Lifeline because they are sitting there waiting for your call twiddling their thumbs and very keen to talk to you. Most people are happy to do that. My only issue, and I have certainly referred people to the national callback service, is that it is very limited. And Lifeline is the same. Lifeline telephone counsellors these days will not spend two and a half hours on a phone call to a client anymore. They simply can’t. They have got too many waiting in the queue to be spoken to.

Senator BOYCE—Lifeline are suggesting sums of the expanded mandatory federally funded service.

Ms Pearse—Yes. I think telephone counselling is wonderful on so many levels. It is anonymous, it is accessible, there are so many levels, but it will still have to refer. If someone has, for example, a housing issue and that is part of the catalyst for them thinking about suicide because they have got a family that are living in a car, Lifeline telephone counselling service cannot address that. So they are still going to have to refer into local services. In my experience, the issues that are surrounding suicidal people are things that are time intensive. They need care and attention and time to help address these issues so that they can create the space in their mind to start thinking clearly. Lifeline cannot do this at the moment.

Ms Camp—And there is a problem with the hospitals.

Ms Pearse—There is certainly a problem with the hospitals, with great respect to them. I have got a great deal of respect for our public health system, our public mental health system, but they are absolutely snowed. They simply cannot respond to people. I am working with a chap at the moment who spent a number of months in a psychiatric unit and he is getting very little attention on release. What can you do?

Mr Anand—Just a couple of things that Carla may be able to give examples of. One is that a lot of the things that are cluttering up people’s lives and making it difficult for them to find the space that you mentioned are completely practical things that are nothing to do with therapy or counselling or anything medical but still need to be worked through. The second thing is that there is often a need for a person to be prodded. The psychologist can say, ‘Come and see me in a month’s time,’ but if they do not the psychologists is not going to chase them. They may need to be steered a bit.

Ms Pearse—That is part of our model of service as well, that it is a very client centred model. Even after they have exited our service I will ring them a month, two months later, a week later, and just say, ‘Are you still doing okay?’ so that they are confident that they can actually come back if they need to come back. I absolutely agree with what Myvanwyn said, that people only know what they know. If you do not give them additional information, nothing will change for them. Again I can only speak from my experience, but the people I have worked with given different information, given different tools, do find hope and optimism and they do continue to live and their suicidal thoughts either diminish or cease. From my perspective it is not rocket science.

Ms Camp—I have seen in a couple of our cases that men who go to hospital are really in a bad place and then they are sent away four hours, six hours later being told, ‘You need help.’ They went to the hospital to get help. They are sent away and they think, ‘No-one can help me. If I go to the hospital and I can’t get help when I am at my lowest, no-one cares.’

Mr Neame—Madam Chairman, I want to correct a few misconceptions because it is obvious from your questioning that you have these misconceptions. Schizophrenia is by far the greatest cause of suicide. I know that depression is getting great publicity, but in my submission I provide you with the evidence that it simply is not the major cause of suicide; schizophrenia is. I know of no evidence anywhere in the world where phone calls and talking prevent suicide. Suicide, by definition, is self-evidently life threatening. If you do not respond when the person first presents, then you will have a high rate of suicide. You talk about attention seeking—and other words have been used today. The person who burnt the Childers backpacker hostel and killed 15 young people was regarded as an attention seeker. He had a long history of contact with the services and he had left 12 suicide notes around the place. So let’s stop mucking about and get serious. Schizophrenia is by far the greatest cause of suicide.

As I say, I have read plenty of reports produced by people like you. You are still wedded to that model—the Durkheim model of sociology. The fact is that people like you and I do not threaten suicide, let alone complete suicide, when we are upset about things. Expecting people to act rationally because they have talked to someone over the phone is absolute nonsense. It is a misconception; it simply does not work. If you do not provide—these are terrible words from the committee, I am sure—a place of safety, you will have a high death rate.

Ms Camp—There are many roads to suicide and the issue, especially for schizophrenia and bipolar disorder sufferers, is a very serious one and they must be taken seriously wherever they present. I certainly do agree with that, but we know that depression is also one of the roads to suicide and certain other life events. But we have to actually look at the rest of the life events as well. One of the things that comes up frequently in our phone calls, of course, is childhood abuse.

Mrs Clark—The White Wreath Association does not really get that many phone calls. What we do get is hundreds of emails—email after email—because people today are using the technology of the internet, basically. I will come back to Lifeline, but I know that we receive mainly emails, not phone calls.

Returning to what Peter said, Peter is our research officer and, yes, the White Wreath Association has gone along the line that, when somebody first presents and they say they are suicidal, for heaven’s sake, you take them seriously. You do not muck around with talking to them and telling them the sky is blue and the grass is green and the sun is shining—‘Pull up your socks; life is great.’ These people have been initially diagnosed with some form of serious mental health problem. You do not try to talk them out of what they are trying to do. What you need to do is take preventative measures, like the White Wreath Association. Since its inception, it has been trying to raise funds to build these safe haven centres for those people who suffer with mental health problems, but especially for those who are suicidal. We take those words, ‘I feel like killing myself,’ very, very seriously. Immediately you must be put into a place of safety. And, yes, we strongly believe in medication. However, this medication is extremely dangerous. That is why these people must be put in a place of safety, because it takes five to six weeks for the medical profession to get this medication balanced and right. They must be in a hospital environment. However, we know today our hospital system, not only mental health but the whole hospital system, is depleting.

Our association has not asked the government to give it money. Our association is trying to raise the funds through public donations, and I know that we are going to get there—we are going to get the funds and have a Betty Ford style clinic in this country. That is what we need. We need somewhere for these people to go because this affects all walks of life, all cultures and all ages, regardless of whether they are rich, famous or poor—it makes no difference. Yes, okay, there may be a little bit of discrimination around who can afford this and who cannot afford this, but we have to start somewhere. Who are we going to start with but the rich and famous in this country? We do have somewhere to start. We will start with people who will be paying, because that is the system we have in place today—everybody pays for everything.

Mr Neame—There is one further point. In the first few weeks any psychotropic medication—psychotropic means mind-altering—it does not matter whether it is alcohol or marijuana, increases the risk of suicide. The SSRIs, which are the most common treatment of mental illness at 90 per cent, in the first six weeks increase the risk up to 600 per cent. Trying to treat people in the community on antidepressants increases the rate of suicide.

Senator FURNER—Particularly in your submission you referred to the tools and techniques used in your model. Can you drill down and explain how that operates?

Ms Pearse—The foundation of the model that I use is acceptance and commitment therapy. I do not actually provide therapy as such. CAPS comes from a non-clinical, non-therapeutic model because we have found that to be the most effective. I use it as a basis because I find the simplicity of it is good. It is not simplistic, but it is a simple technique. It is about helping people to understand that negative thoughts, and maybe for some people even suicidal thoughts, are inevitable. It is the interpretation and meaning that we put on our thoughts that is what causes problems. It is helping people to understand how their thought processes work and how they often exaggerate negative experiences in their lives. My experience through my client base has been that I think a significant proportion of them actually are not clinically mentally ill. The Black Dog Institute was mentioned before and I love its use of the word ‘melancholy’. A lot of my clients are experiencing melancholy. They are experiencing a sense of being overwhelmed because of external events and circumstances. Part of what I do is to help them to understand that. I help them to understand that pain and suffering is an inevitable part of life and that you cannot expect not to have that. I have worked with an age range of people going from 15 to 83. An 83-year-old has been the oldest man that I have worked with. There generally seems to be a sense that we should not be experiencing any suffering and so when we do we just do not know what to do about it, we do not know how to cope with it. The acceptance and commitment therapy model is an extremely effective one. It uses mindfulness as a base which dialectical behaviour therapy also uses but it is a simpler therapeutic model.

Senator FURNER—So essentially your clients connect with their feelings about life to help them understand that there are things in life that are not controllable.

Ms Pearse—Absolutely and that is actually okay. We cannot control everything and sometimes we have unpleasant and painful experiences and that is okay. If there is a mental illness involved then I try very much to work from a multidisciplinary perspective so that we connect them into the appropriate mental health services. The thing that I absolutely agree with Fanita about is that if somebody talks of suicide, they need to be taken seriously. We absolutely do that. What we do not assume is that there is a mental illness necessarily as a first point of call. My experience is that they are already under psychiatric and psychological care and it is not working for them because they are not being given the appropriate information, tools, techniques or even hope. A number of people come to me and say, ‘My psychiatrist and/or psychologist hasn’t even talked about the possibility of hope for me.’ It is just sad really. So that is the model.

I am a Buddhist so, if they are interested in Buddhism, then I speak about Buddhist issues. As part of our foundation I use things like impermanence; nothing stays the same; you are suffering today but it does not mean that tomorrow you will also be suffering. I do not come from a Buddhist background; I come from a very secular perspective. I have not been a nun for very long. I am only a new nun. I have been working in this business for a long time as a non-nun person.

Senator ADAMS—As we are in Brisbane, in relation to the accident and emergency area, do you have a psychiatrist or an area that is set aside for people with these problems where they can be completely taken out of the mainstream.

Ms Pearse—My experience with my clients is that they might go to A&E. If they are accepted into the system they will be sitting there for hours and hours unless they have made an attempt. But if they are going to A&E with suicidal thoughts then they are sent home. Where I live on the Sunshine Coast we had a couple of guests that have had significant mental health experiences and I have rung the acute mental health team. They are limited in what they can do. I ring them because I have a duty of care to ring them. But I know exactly what they are going to say, but I have a duty of care to give them a call knowing that I am going to be in no different a position when I hang up the phone than before I made the phone call other than the fact that I have fulfilled my duty of care obligations. With great respect, our mental health system in South-East Queensland—that is where I work; basically in the south-east corner but from Gympie to the border—just does not work for people with suicide.

Mr Neame—There is an area suicide in the Royal Brisbane. You have to remember that in the last 40 years the training has changed. What I learnt is quite different to what people learn today. Their assessment at the frontline approach is what is wrong. Professionals do have to accept a lot of the blame. It is easy to blame managers and administrators and government. The fact is if I do not get my assessment right somebody can die. That is what is happening at the moment. Frontline people are trained at attention-seeking and if someone cuts themselves they are an attention-seeker. If you cut yourself it means (1) you do not have much skin conductivity there—you or I would be screaming in agony; (2) in the anterior cingulate gyrus in the limbic system of the brain you do not register pain. So you are quite a different person than a normal person. Straightaway that one aspect tells you a lot, if you know about the neurology of mental illness. Even prominent psychiatrists know sweet bugger-all about the neurology of mental illness. That is deficient on its own. If you go back to Freud, who you could say was the father of social causation—he was not in fact—he was a neurologist and he was trained first and foremost in brain function. In his old age he said that there are two forces: thanatos, death force, abnormal people; and eros, life force, normal people.

Mrs Clark—I would also like to add to CAPS that we routinely know that people who present themselves to hospital, even after an attempted suicide, are routinely refused hospital admission. That is what I have tabled, which is a very, very recent case of a young lady presenting herself and waiting hours in a pool of blood for treatment.

CHAIR—I just need to clear up the email. Does it have the person’s name on it?

Mrs Clark—I have crossed that out, but I can give it to you with their permission.

CHAIR—We will accept it on a confidential basis.

Mrs Clark—Yes, I can give you their name.

Senator ADAMS—As far as young people go, we had BoysTown giving evidence earlier and yesterday we had the people from ReachOut with their website. With young people using the internet more so than they are the telephone I am wondering, if a younger person rings any of the organisations, do you refer them to any of the websites? How do you deal with them?

Ms Camp—We will even refer adults to particular websites. If they are from the Cairns region, we refer them to the Koch website. There is a lot of good information on it. It even gives hospital numbers—for example, for Tully—and things like. So we will refer them to that website. I quite admire what they have done; they have done a lot. We refer people to the Suicide Call Back Service website, the Black Dog Institute and beyondblue et cetera. There are various other websites that we will use, depending on what the call is about.

Senator BOYCE—Do you use blogs?

Ms Camp—Not so much blogs, but there are two particular site forums, which are well run, that we use for the bereaved. We obviously do not have the expertise to go into the make-up of everything that is on the web, so we try to stick to those that we know.

Senator ADAMS—On the issue of your consultation with Aboriginal and rural and remote communities, would you be able to give the committee an outline of the plan that you use? You were saying that they have a community plan.

Mrs Bird—Yes.

Senator ADAMS—It would be very useful for us to have a copy, if we could.

Mrs Bird—Okay. In the Northern Peninsula Area, we are having a workshop next week for the community and, from that, we are going to be identifying people, especially young people, who might want to be trained to be like community liaison officers. We hope to find 10 people in the communities—two from each of the five communities in the NPA. We will be going up there once a month. We need to keep in mind that it is very costly to travel from Cairns to Bamaga. For example, it cost me $289 to fly down here and back today, but it cost me $1,000 just to go that short distance to Bamaga. So we can do it only once a month. Every month we will go there to teach these young people and work in the workshop. We will go over what they need to know to do interventions and how to go around the community. We have a person in Yarrabah, which is an Indigenous community not far from Cairns. Communities in this area are so close-knit that they know everything that is going on—for instance, if there is an accident or a suicide in the community. Mary will call in and have a yarn and a cuppa or she will stop and chat in the supermarket to someone. People do not have to know that they are talking to her because they are suicidal. It is just a friend dropping by. That is how we operate in all of these communities. The community liaison officers will be able to seek out these people and have a yarn with them and so forth when we are not there on the ground.

Senator ADAMS—Have you applied for any government funding to run these workshops?

Mrs Bird—Yes, I have with Department of Health and Ageing.

Senator ADAMS—Not successful?

Mrs Bird—Still waiting—waiting, waiting. Every time I ring, they say, ‘Oh, we haven’t made a decision.’

Ms Pearse—I think it is a really important point that Dulcie has made. Again, that is one of the things that we do, which is going out into the community. We do not make people come to our office and sit in a therapeutic room for an hour. We will meet them in a coffee shop or under a tree. We go out into the community and do it in a very relaxed environment. This response is more effective than someone having this sense that they are going to see yet another therapist. I think even just doing something as simple as that can have an enormous impact on somebody’s mental and emotional wellbeing.

Ms Camp—I grew up in the Northern Territory and we had a Salvation Army minister who went from property to property. I am quite sure that he saved many lives, not just for God. He was there administering for God but he was actually providing a lot more than that. This is important for isolated communities. It was because he went everywhere that no-one felt that they were being targeted. In fact, they retired him because they were afraid that people were thinking of him as God.

Ms Pearse—Another important factor is oftentimes people who are seriously caught up in their suicidal thoughts simply do not have the physical capacity to go somewhere. Picking up the telephone and making a call to an organisation like CAPS has taken their last bit of resource. Invariably, the majority of models of service for a suicidal person is that you come to me. For many of them, they simply cannot do that.

Senator BOYCE—There are multiple doors to try and get through as well.

Ms Pearse—Indeed.

Mrs Clark—Can I respond to that? I disagree with that because nearly every person has family support and very strong family support—I strongly believe that they do. It is a minority that does not have family support. If we did a simple survey in here, I am sure all of us or 99.9 nine per cent of us support our families.

Senator BOYCE—There would be those who have chosen not to share their problems with their families. I want to ask Ms Pearse and Mr Anand about some comments you made in terms of medication, particularly antidepressants, the timing of their use et cetera. Would you like to comment a little more on that for us please.

Ms Pearse—Again, I can only speak from my client base, but it is a fairly clear theme with the people that I see: they will go to their GP in the first instance and talk. They may not talk suicide but they will talk about the fact that they are depressed and feeling down and, necessarily, they are put on an antidepressant of some description.

Senator BOYCE—Necessarily because the GP is concerned about a duty of care?

Ms Pearse—I would suspect so and because they do not know what other questions to ask to find out more information. I think it is reasonable to accept that we have a medical model response to somebody who talks about depression, so we automatically provide that clinical response. From there they may in fact get a referral into a psychiatrist or a psychologist but what I find in probably the majority, of my clients is that they are saying the medication—and they may see me a week after going onto medication but they may see me two years after trying to slog it away on medication—just is not making a difference to how they are thinking and feeling. That says to me that something is not working with the whole medication thing.

Often they will go back to their GP and try some different things, so it is not that are being dormant about their activity. It would be a reasonable inference or educated guess to say that they are probably not clinically depressed; they are experiencing melancholy. They may be going through grief. There may be multiple issues. It might be that they are simply trying to have a family survive living in a car. Because they are talking depression, they are automatically medicated. The trouble is that they take medication with an expectation that it is going to fix them and it does not fix them.

Mr Anand—Then they feel like a failure.

Ms Pearse—Then they feel like it is just reinforcing the message that there is nothing.

Senator BOYCE—I suppose if you are still alive after two years on the wrong medication, maybe it was the right medication in some cases.

Ms Pearse—Maybe.

Mr Anand—Also it is important to clarify that we are not saying that medication never works; we are saying that the people that come to us are the ones that it has not worked for.

Ms Pearse—For some it works. There is no doubt and I have no problem with that. They are saying that there is a shift in how they feel. Some people’s survival is pure determination more than anything else. I have no aversion to medication at all. I just want it to be given appropriately. Similarly, with any mental health response, I want an appropriate mental health response given, not just a standard one-size-fits-all response because people do not know what else to do.

Mr Neame—The evidence is that SSRIs do not prevent suicide.

CHAIR—We have run out of time as per usual. Thank you very much. Your time, evidence and submissions are very much appreciated.

[12.06 pm]

CAMERON-HANDS, Mr David, Executive Officer, Anti-depression Association of Australia

McLOUGHLIN, Mrs Carol, General Manager, The Mentoring Institute

CHAIR—Welcome. I understand you have been given information on parliamentary privilege and the protection of witnesses and evidence. We have your submission. I invite you to make an opening statement, and then we will ask you some penetrating questions.

Mr Cameron-Hands—First of all I would like to thank the committee for extending this invitation to us. It is quite a wonderful opportunity for us to share with you something which we think is quite wonderful. I would like to start with a personal declaration; if it is not clear why I am doing that now it may become clearer throughout my preamble, before questions. I am a former retreat manager at the Fountainhead Organic Health Retreat in Maleny and also was a senior lecturer for the Australian Depression Institute prior to my current post as executive officer for ADAA.

Before I get into my opening remarks, I would like to say that I have read an awful lot of submissions and found them to be absolutely wonderful. I would like to congratulate everybody on the quality of the submissions that have been made. In particular I pulled out a few which I think tell an extremely telling story. I found some of the individuals’ submissions to be extremely emotionally charged, as you would expect, and some of them quite harrowing. The majority of those paint a picture of difficulty in accessing services. I think that would be a fair comment on the individuals’ submissions that I have read.

I think Lifeline have very articulately separated out the need to focus on prevention, intervention and post intervention for those family members and loved ones who may be left to pull themselves together after a tragic event such as suicide. The Australian Society for Psychiatric Research very beautifully described issues in funding for research specifically into suicide and also depression when compared with other diseases such as obesity and heart disease.

I am really looking forward to meeting CAPS later, simply because of their client-centric approach and the model that they use of acceptance, which is very similar and close to what I am going to be talking about later today. There is some great synergy and hopefully we can do some work together later on.

And finally, Jane Pirkis, from the Centre for Health Policy, Programs and Economics in Melbourne, describes some work by Mann et al, who only arrived at two successful strategies: the first one was to prevent access to methods of suicide, and the second one was to up-skill, up-educate clinicians in the early detection of diagnosis and treatment thereafter of depression. There is something very significant missing from those two things—that is, lack of strong evidence of a solution at the client point. It is something which, as an organisation, ADAA will be looking—to put it in plain English—to put a hole in basically, to do something about.

All of the submissions have very adequately described the mental health waters in which we all drown in to the committee. I do not think further description of the water is necessary. ADAA will take a position on bringing together workable solutions to help people with stress-related illness, anxiety and depression.

A little bit about our organisation. It is very, very new. My guess would be that most people in the room will not have heard of us. We were established only over the last few months, which is why I really do appreciate this forum to speak to you. We are based on the Sunshine Coast. We are a not-for-profit organisation. We will build on the awareness that fantastic organisations such as Black Dog, beyondblue and Lifeline have done. As I said a little bit earlier, our intention is to continue with the awareness work but to accept, as said I before, the landscape is very clearly described for us now. We know exactly what the landscape is. We feel that there is the need for somebody to bring all of these wonderful working solutions together for the benefit of sufferers of stress-related illness, and the direct benefits of that would be the prevention of suicide.

I would like to introduce you to the particular method which has been put forward to ADAA. The role that we have as an organisation is to search workable solutions for stress-related illness. A particular method has been presented to us, which is very exciting, and it is that which I wanted to share with you. But before I do that, I want to read a passage of text that I picked up from the internet last night. I was having a look to find out what the prevalent thinking is on how to be successful in our lives. I have highlighted some pertinent words here:

> In order to have success in our own lives we must first define, within ourselves, what it IS to be successful and then set our hearts and minds on achieving it.

Achieving is underlined.

> The basic foundation to attaining success is setting goals and when you achieve those goals, you have success.
>
> The goals that we set for ourselves can come in all shapes and sizes. Some may seem small and some may seem outrageously ambitious in the eyes and minds of others. Whatever the size of the goal or whatever the goal is, when we accomplish it, it will equate to success no matter how big or small.

Those are profound words. This is prevalent thinking in society today that attaches personal value, personal worth to achieving or keeping something. At ADAA, through our understanding of the Fountainhead methodology that has been presented to us, that type of thinking, when it does not go to plan, causes significant difficulties for the majority of people. There is heaps of research out there, mainly European and American research, which backs up that statement.

The method that I want to talk to you about is very closely linked with a little bit of what Ms Pearse said from CAPS. It is a method which recognises that it is not specific life events that cause psychological stress, anxiety and depression; it is the way each of us as individuals looks at those particular events. We know that because each of you may have friends or family members, or even yourselves, who have experienced a similar life event, or even the same life event, but their life's journey and course thereafter has been very different. The defining thing between the two individuals is only how each of those individuals looks at that event. That is shaped entirely by what it is that we learn through our life to that point, through our parental or caregiver input, our social conditioning, media et cetera. All of those things form very strong belief systems in all of us, and we use those belief systems to shape our own lives, to develop the codes by which we live. We do that in a way to help ourselves survive, if you like, to be life affirming. It is only when those belief systems and those codes are challenged by reality that we have a problem and we have something to deal with, and what that looks like is psychological stress, anxiety and depression.

The method that Fountainhead has presented to ADAA is a method which strongly indicates that people who suffer psychological stress very strongly link their own identity and worth and value to the achievement of something or to having their life be a certain way. And all of that is in line with exactly what it is that they have been taught, what it is they have learnt.

The method is currently available privately, so it is a programmed approach. At the moment this is through a program which is available in Maleny on the Sunshine Coast, but there are attempts at the moment to make the program and methodology available nationally. So the idea is to make what at the moment it is something that is not as accessible as it could be for lots of people, for clear reasons, as accessible as possible.

The success of the method, judging by the information and the evidence presented to me, at the moment is anecdotal. We need to be very clear about that. There are client testimonies. The more than 4,000 people, which is not a small number of people, who have benefited from the method have provided client testimonies. At the moment there is a more rigorous approach being taken to the assessment of its efficacy in conjunction with some research. Queensland Mental Health and the University of Queensland were going to do a 12-month longitudinal study, so I am very much looking forward to being presented with more positive and objective efficacy results, as opposed to the very subjective stuff that we have at the moment. However, I must say the subjective stuff is very compelling.

I guess what I am talking to you about and what I am trying to convey to you is a practical solution, in keeping with what CAPS communicated earlier. I do not know that I would have been brave enough to use their words—they said it was not rocket science—but I absolutely agree 100 per cent with them, and I am glad they said that before I had to contemplate saying it. It is not rocket science. The approach that we have is very straightforward, it is very practical. It does exactly what Ms Pearse said. It predominately does two things: it gives people more information—that is, education—and it gives them the space in which to interpret and process that new information. That appears to be extremely powerful.

Because the methodology is looking at the root cause the retreat believes of psychological stress, anxiety and depression, it would appear that the method is not a sticking plaster approach; it is a fundamental—it is not therapeutic, it is not clinical, but I will use the word ‘intervention’—intervention. It is very preventative. Because it requires a change in thinking, then the earlier an individual understand and is exposed to this information, the greater the chance of benefit.

Senator MOORE—It would seem that until we get the assessment of your program it is difficult to ask too much about it. Your submission says that a number of people have been through the retreat process at Maleny and have benefited from it, but that could apply to all kinds of experiences. It is positive that you are getting independent assessment and, through that process, could get into the tools that are used. I wonder whether the access to the process is known by the agencies that people turn to for support. Do places like Lifeline, the alliance and the various community groups that work with people or the families of people who are depressed know about the process? Can they access it that way?

Mr Cameron-Hands—Not at the moment, but that is certainly on our communication plan.

Senator MOORE—Good.

Senator BOYCE—Can you comment on the point that was made earlier today and yesterday about depression and melancholy—the problem that we may be developing where, having in large part succeeded in destigmatising depression, we are turning it into a flavour of the month and not regarding it as a serious mental health issue? Could you tell us about what your client base is and what you think about that idea in general?

Mr Cameron-Hands—What was communicated by the panel earlier resonated with me. I think there are lots of people who attend the retreat who maybe have been told or presumed that they are depressed but are melancholic—they are just a little bit low. For me, the differentiator for the diagnosis of clinical depression occurs when you get the chemical change. That, for a lot of people, is not there. The method I am describing to you is different; it does not use specific, well-known medical models to define and to diagnose. What we have been able to do is assess similarity in thinking between people who suffer psychological stress. It is the same for anxiety and depression. There is a ‘why bother’ belief system that exists with people with depression. There is a ‘control and prevention’ belief system that exists with people who suffer from anxiety. With psychological stress there is a ‘lack of acceptance of events’ belief system.

The real challenging question to ask when we are considering suicide is what makes somebody take the step from despair to suicide. There is an awful lot of despair; there are far fewer cases of suicide. What makes somebody take that step? We believe that what makes people take that step has its base firmly in worth and self-esteem. An individual’s perception is that their worth and life value continues to drop to the point where it becomes unpalatable for an individual to look beyond that moment to them feeling less worthy than they are then. To exit at that point is their final bit of control that they can have to take with them the value that they have at that moment in time. If any of you have had the opportunity to talk to anybody prior to them committing suicide, you may have heard stories of physical pain. Individuals describe it as every cell in the body emitting pain. I have no idea what that must be like, but I can sympathise. So are we in danger of trivialising? I think we already have.

Senator FURNER—Of the 4,000 clients that have presented themselves to the retreat, are you able to identify how many may have been suicidal?

Mr Cameron-Hands—Not with the current level of data collection, no. That would have to be part of the prospective work that the retreat does from this point moving forward. Any number or any estimation would be difficult to pin down factually, I believe, at the moment.

Senator FURNER—There has been a lot of discussion today around front-line personnel, whether it be police, whether it be ambos, not being able to identify someone as suicidal. Just the mere fact that they may have indicated that they wish to kill themselves would not necessarily be a trigger. Are there other ways, in your experience, to identify someone that is suicidal so that we can educate everyone, if possible, about the importance of having that knowledge, of making people step in and prevent that act happening?

Mr Cameron-Hands—I believe that the real marker lies in how an individual communicates their value and how they feel about their own value. That can almost be independent of mood with some people. I think it is how an individual feels themselves and communicates how valuable they feel socially, how valuable they feel within their own family unit, how valuable they feel as a person. It is an individual self-worth value estimation. I believe that is a good marker. But that on its own may not be enough as a predictor. You will have different people in different walks of life who will have their own threshold for how low they are willing to let their own worth and value go perceptually. It is not as clear-cut as saying that everybody would start with 100 per cent worth and value and, if people were to articulate or we were able to spot articulation of 10 per cent worth or what have you, that would be a marker. I do not think it is as clear-cut as that. If you are a captain of industry and you are used to being at this level, if you were to lose some of your worth that might be enough, for some people, to trigger the act that we are talking about. It is complex.

Senator ADAMS—Approximately how long do your clients remain at the retreat?

Mr Cameron-Hands—That varies. The best results reported are with clients who stay at least for 28 days. Through that 28-day period the client would have experienced the various elements of the program, which include one-to-one mentoring, group mentoring, weekend intensive therapy, mindfulness therapy and journey therapy adjunct approaches. I believe success has been seen with clients who stay a shorter time. My own personal experience, having worked at the retreat previously, is 28 days, one month.

Senator ADAMS—What about follow-up?

Mr Cameron-Hands—The retreat is committed to two elements of follow-up. There is following up with the individual who attended the retreat through further telephone mentoring. There is an opportunity for that. That is not a predetermined amount of time. That can take as long as is agreed. Also, there is a reintegration program to help loved ones and family members to understand exactly what has happened to that individual—the new information and the new life approaches that that individual will have learnt about. If you are waiting at home for your loved one to come back, it will be a different person. It is very, very powerful, very, very supportive, to have your family members and loved ones on the same page as you when you return, even just from a language perspective.

Senator ADAMS—So how much time do you take orientating the family?

Mr Cameron-Hands—Family members are encouraged to take part in the weekend intensives, and some family members have taken up the opportunity to do group week mentorings. There is also an additional bit of the program for clients at the retreat to learn how they can communicate what it is they have learnt.

Senator ADAMS—How many people have you had readmitting themselves?

Mr Cameron-Hands—Again, I could not put my hand on my heart and give you a definite figure for that. My personal experience is that, yes, people who have been there before do come back to the retreat. Some people go back to the retreat because they have a genuine need to continue to work with whatever it is they have worked on. Some people go back to the retreat because they enjoy the environment and they just want a top-up on general information, rather than because they have to address something in particular.

Senator ADAMS—Mrs McLoughlin, what is your role? Could you give us a brief description of what you do?

Mrs McLoughlin—I was the general manager of the Fountainhead Organic Health Retreat for a period of time. Now I have seen the opportunity to use our methodology out in the community. My experience was that a lot of guests had come to the retreat, learnt the new methodology, significantly changed the way they thought, had gone home and wanted to share it with their families. Hence, the phone calls would come—as David said—from the families wanting new information as to what had occurred to the family member whilst they were at the retreat. This has enabled me to look at a broader scale and how we can get it out there. This is why the Mentoring Institute was implemented. We are now taking the methodology out into the community—for guests, family members or people who are interested in learning about our methodology but who cannot come to the retreat because they cannot afford the time or the money to be there.

Currently, I have an office in Brisbane and one in Melbourne and I was in Alice Springs last week looking at opening a branch there. There is a real need in the community there to teach our methodology. The Fountainhead method was born at Fountainhead but now it is time for it to move into the community. We need to teach this to everyone who can learn it, as early as possible.

I worked at the retreat as a general manager. I have seen the benefits of it—for people who come with depression, anxiety, addictions, stress related illnesses, post op and pre op issues—and I have seen significant changes once people learn to use the tools that we give them. That is why we are trying to get out into the community and teach what we know. It is a valuable tool and what we are doing is pretty exciting.

Senator ADAMS—One more question. Do you refer on to any other organisations? Do you have any partnerships with anyone else or do you just stand alone?

Mrs McLoughlin—At present we stand alone. We have a lot of medical people who come to our retreat—doctors and psychologists—to learn our method and to implement it in what they are doing but we have not connected with anyone at this stage. We stand alone with our method but obviously we are looking to get our message out there as much as we can because we see a real need for it.

Mr Cameron-Hands—From an ADAA perspective, a primary goal would be to partner with currently existing agencies who are doing fantastic work.

CHAIR—We have run over time, as usual. Thank you very much.

Proceedings suspended from 12.34 pm to 1.35 pm

RITCHIE, Ms Angela, Manager, Child Death Review, Commission for Children and Young People and Child Guardian, Queensland

CHAIR—Welcome. I understand that you have been given information on parliamentary privilege and the protection of witnesses and evidence. We have your submission and would like to invite you to make some opening comments, and then we will ask you some questions.

Ms Ritchie—Thank you. Firstly, I would like to thank you for inviting the Queensland Commission for Children and Young People and Child Guardian, or the commission, to appear before the Senate hearing today. The commission is an independent statutory body charged with the responsibility for protecting and promoting the rights, interests and wellbeing of children and young people under the age of 18 in Queensland. Since 2004 the commission has been mandated to maintain a register of all child deaths in Queensland and to analyse the information contained in this register to identify trends and patterns in child deaths and to make recommendations aimed at preventing deaths from occurring. Over the past 5½ years the commission has undertaken a significant body of work in relation to the issue of youth suicide in Queensland., with many of the terms of reference raised as part of today’s inquiry aligning with the commission’s previous findings as published in our annual child death reports and also through the work that we are progressing through our Reducing Youth Suicide Queensland project.

The commission welcomes the opportunity to make submission to the Senate inquiry and to appear today. Our research findings and data relating to youth suicide in Queensland today are quite detailed and are outlined in our submission, but there are a number of key points I would like to take this opportunity to highlight for your attention. To date we have released five annual reports in relation to the data contained in our child death register. This data shows that in the five-year period 1 July 2004 to 30 June 2009, 85 Queensland children and young people have taken their own lives. Fifty-six of those were male and 29 female. All were aged between 10 and 17 years, with 20 of those actually 10 to 14 years of age. Twenty-four were Indigenous and 61 were non-Indigenous. Between 2004 and 2006 the commission also identified suicide to in fact be the leading cause of death for children in the 10- to 14-year age group., and the second leading cause of death for the 15- to 17-year age group, with deaths in the 15- to 17-year age group are only being exceeded by transport fatalities. Until the commission’s child death review functions commenced in 2004, the disturbing rate of suicide for the 10-to 14-year-old age group had not previously been identified in official data sets.

Upon further investigation we identified a number of historical, legislative and procedural barriers that contributed to the underreporting of youth suicide in Queensland. These included issues with coronial processes, in particular coronial findings not specifying intent, which had a corresponding impact on the coding of suicides using the International Classification of Diseases, often referred to as ICD10, which is a classification that has been developed by the World Health Organisation and is used to code causes of death worldwide and is used by official statistical reporting bodies. These barriers had in effect resulted in suicides being classified as accidental and thus the true incidence of childhood suicide was effectively hidden from view. By way of example, in 2004 the commission entered 12 suicides in its child death register whilst the ABS reported on seven. For this sample that equates to over 40 per cent of Queensland suicides not been reported.

Before progressing substantive research into the issue of youth suicide based upon our child death register dataset, the commission considered it was necessary to first undertake a range of actions to improve the accuracy and understanding of suicide for classification and reporting. This included consulting extensively with key stakeholders, including the Australian Bureau of Statistics and our state coroner, making a submission to the World Health Organisation regarding international coding practices, to which appendix 2 of our submission to the inquiry refers, and making several recommendations through our child death annual report to improve the reporting of suicides. These recommendations are outlined in appendix 3 of our submission.

Having taken those significant steps to address the issues associated with reporting, the commission has now commenced substantive work to respond to the high number and young age of children and young people taking their own lives through our Reducing Youth Suicide in Queensland project—RYSQ is the acronym. The RYSQ project is a detailed review of the lives and deaths of 65 Queensland children and young people who took their own lives between 2004 to 2007. The project includes a detailed review of records from all Queensland government agencies that had contact with those children and young people in their short lives. This project is unique and it is contemporary. It is intended to improve our understanding of the factors that increase suicide risk among children and young people so that we can develop future prevention efforts.

The key findings of our work in this area have been outlined in detail in our submission to the inquiry. I will take the opportunity, however, to emphasise a couple of points briefly. In the RYSQ study period of 1 January 2004 to 31 December 2007 42 per cent of youth who suicided did so after the suicide or attempted suicide of a friend, family member or community member. The contagion process that leads to suicide among young people reinforces the importance of detailed suicide prevention and postvention guidelines and services being put in place. In the past, postvention services could have confidently been targeted at family and friends, and in particular the school community. However, the proliferation of electronic media and social networking over the internet presents new challenges in targeting such services to a potentially anonymous, diverse and an instantly updated group.

There are also distinct differences and similarities between Indigenous and non-Indigenous suicide that serve to highlight the need for tailored responses to better target the incidence of suicide in Indigenous youth. Finally, 63 of the 65 children considered as part of our RYSQ project had significant behavioural and disciplinary problems. For example, they had been suspended or expelled from school or in contact with the police and youth justice system. This finding does not align with the popular belief that most children who suicide are introverted, withdrawn and bullied and may challenge educators and service providers to young people to revisit some established approaches.

The death of a child is a tragic loss to not only family and friends but also the broader community. When the death occurs by a young person’s own hand the impact is undoubtedly immeasurable. It leaves many with unanswered questions and wondering what could have been done differently. While we may never know the exact reasons why young people take their own lives, we must try to understand as much as we can about these and use this information to inform our prevention efforts. On behalf of the commission I commend the Senate for making this important issue one of its priorities and look forward to answering your questions.

Senator MOORE—Ms Ritchie, one of the things that has been a common element of this inquiry has been the concern about data. In reading your submission it seems that one of the first steps was your concern about data and steps you had to take to be more confident with the data that was publicly presented. I am interested to know whether there are similar exercises going on across the country, because our aim must be a standardised approach to data collection. Are you aware of any similar activity going on in the other states and territories?

Ms Ritchie—No, I am not aware of other states and territories progressing the issue in the form and with the level of advocacy that the commission has. However, in taking steps to address this issue at a national level, the commission did extend recommendations to the Australian Bureau of Statistics to address the issue, particularly for suicide not being classified for children under 15 years of age. As a result of our work in that area, the Australian Bureau of Statistics has taken some steps to improve the data capture and recording insofar as the cause of death information upon which its official statistical dataset is based is concerned.

However, in the Queensland context, if I may use that as an example—I believe it may be equally relevant to other jurisdictions, and that is an issue that would need to be explored—we identified that, if a coroner did not specify intent in coronial findings and the cause of death was given as, say, hanging and did not say ‘accidental’, there is a reluctance among ICD-10 coders to assign that death as intentional. Consequently, those deaths default to accidents. Given the nature of the commission’s child death review processes and the breadth of information we have available in comparison to statistical bodies at the Commonwealth level, we are able to better identify those cases and appropriately assign them as suicides. The limitations that we have identified therefore may equally apply across the board at state level and would need to be addressed.

Senator MOORE—And the acceptance of the clarity of intent for children could be applied to all ages. There was a particular point expressed in the paper that one of the things coroners were concerned about was intent and knowledgeable intent of minors—I think that was the term used. In terms of classification, that sensitivity is extended to all age groups, so the data that we have for any death in Queensland and, I think, other jurisdictions as well is limited in the clarity of definition when we are trying to make a case around suicide. Was that your experience?

Ms Ritchie—Yes, that would be correct. However, we consulted with the state coroner. Interestingly, the Coroners Act 1958 was repealed and replaced by the 2003 act—

Senator MOORE—Which I have not read!

Ms Ritchie—and there used to be prohibitions on coroners actually making a finding as to intent in the context of a suicide. That prohibition was removed when the 1958 act was repealed. When we consulted with the state coroner, he was of the view that, if a death was accidental, the finding would state as such and, in cases where the finding is silent and the death is indicated to be a suspected suicide, it should be taken to imply that the death was intentional. I am not aware of such prohibitions to specifying intent to exist in other jurisdictions.

Senator MOORE—We will have to chase that up to try to get a standard process. I have a lot of questions that I will not ask because of the time, but the work that has been done by your office is exceptional. I think it could be a model for other places.

Ms Ritchie—Thank you.

Senator BOYCE—I want to follow up on Senator Moore’s question about data. You said there had been some steps by the ABS to include children under 15 in its suicide stats. Do you mean they are now being recorded or it is being looked at?

Ms Ritchie—At this point it is being looked at. I guess because the ABS are reporting from the national perspective and are using the World Health Organisation classification, they are going to have to work through a number of steps. For them it is in effect a change to the application of the ICD-10 coding and they have formed a working group to further explore the issue. The commission has also made a submission to the World Health Organisation requesting an amendment in the next revision. It will become ICD-11 and is due in about 2011 or 2012. If that submission is accepted, it will have corresponding impacts for how the ABS then goes on to capture and record those stats.

Senator BOYCE—You mentioned that in 2004-05 the ABS had seven child suicides in Queensland and your figure was 12. Has that disparity changed since then or does it still exist because you are using different coding mechanisms?

Ms Ritchie—Yes. Because the commission has developed a robust screening methodology, which we go through to classify all deaths which are suicide or suspected suicide, that would be the case. Whereas ABS relies on cause of death only, we use a range of authoritative sources.

Senator BOYCE—Just for the record, why is your minimum age 10?

Ms Ritchie—It is not that it is the minimum age; it is what we have seen in the data—the youngest age we have recorded for childhood suicide is 10 years of age.

Senator BOYCE—Okay. I asked some questions around child suicide yesterday, and the ability to have intentionality was raised as an issue.

Ms Ritchie—Yes, that is an issue that has been raised in research literature. In the past it was considered an impediment to deaths actually being recorded as suicide, because there were questions about the capacity of a child to understand the consequences and irreversibility of their actions. But, increasingly, the research literature is suggesting that children do know enough to contemplate suicide, and it needs to be recognised as such.

Senator BOYCE—So you are looking at all children; presumably not from age zero, but—

Ms Ritchie—Yes, we look at all children. I would certainly hope that there were no children under the age of 10.

Senator BOYCE—I just want to clarify something. You talk about contagion suicide following the death of a family member, a friend or a community member. What do you mean exactly when you say, a ‘community member’?

Ms Ritchie—Any member in the community where we identify that there is a reasonable likelihood that the person would have known or learnt of that death.

Senator BOYCE—Like a next-door neighbour?

Ms Ritchie—Exactly. Also with someone in the community whose death is reported in the media and the young person could have reasonably become aware of the death. But certainly a death that occurs and, in all likelihood, they were aware of it; and where we can identify, through the body of information we have in respect of the young person, that they did in some way become aware of that death.

Senator BOYCE—You made the point that, with Facebook et cetera, a 'community' is no longer a physical location. Have you looked at how one reaches out to that virtual community?

Ms Ritchie—No, to be honest we have not at this point. But it is an issue that we have identified through our work to be a challenge that does warrant further consideration.

Senator FURNER—Page 6 your submission really highlights this point about correct identification of the reasons behind the suicide. It is a scary figure that Queensland is showing nearly double the national figure. With regard to the stats on Aboriginal and Torres Strait Islander children, do you have the breakdown of what communities they came from?

Ms Ritchie—No, I do not have the information in terms of communities available today. What I can provide you, though, is the Indigenous data I have been looking at in terms of the accessibility and remoteness index—so, they are classified according to whether or not the deaths are occurring in remote or inner-city areas. The data was actually quite interesting. To give an example: for the suicides considered as part of our Reducing Youth Suicide in Queensland project—65 suicides in total, of which 18 were Indigenous—when we look at those statistics as a whole it appears that the majority of suicides are occurring in city areas; however, when we disaggregate the statistics, and look at them by Indigenous status, we see that the majority of Indigenous suicides occur in remote and very remote areas. To give you some statistics on that: there were 18 Indigenous youth suicides considered in that project, of which eight occurred in remote and very remote communities—so, 44 per cent of the total Indigenous youth. Comparatively, only one non-Indigenous youth suicide occurred in a remote or very remote area in that time period. So the disaggregation of the location of the incidence by Indigenous status actually paints quite an interesting picture that they are in fact occurring in the more remote parts of Queensland.

Senator MOORE—Is that using the definition of 'remote from Brisbane'?

Ms Ritchie—Yes.

Senator MOORE—So a place like Mount Isa would fall under that definition, even though it is a town?

Ms Ritchie—Exactly, yes.

Senator MOORE—They would say a city, but it means a significant place.

Senator Boyce interjecting—

Senator MOORE—I know, I am being careful!

Ms Ritchie—For example, 'remote' would be Charters Towers; 'very remote' would be the very far west parts of Queensland.

CHAIR—So the eight were effectively anywhere outside the Brisbane metropolitan area. Would that be a correct interpretation?

Ms Ritchie—Sorry?

CHAIR—The eight deaths that you identified as Indigenous and remote were basically anywhere outside the Brisbane metropolitan area.

Senator BOYCE—South-East Queensland.

CHAIR—Sorry, yes.

Senator MOORE—I think the coast—

CHAIR—Okay, so not the coast.

Senator BOYCE—And not Toowoomba.

CHAIR—Sorry, I am from WA.

Ms Ritchie—That is all right. The index of remoteness is basically derived by measures of road distance.

CHAIR—So you are using the index of remoteness.

Ms Ritchie—Yes—populations, localities and service centres. So very far west Queensland falls under very remote.

CHAIR—I want to follow up on the contagion issue. There is the 42 per cent figure, but it is a cascading process. If somebody has suicided as a result of the suicide of somebody who is close to them or from the community, that person who suicided before them could also have been affected.

Ms Ritchie—Potentially—for example, in the context of a child affected by the suicide of their parent. There are two types of contagion. One is familial contagion—that is, the death of a family member, as it implies—and there is imitative contagion. It has been recognised that a small but statistically significant number of adolescent suicides occur in time-space clusters. For example, a youth may have a friend that suicides, or it may be a student in a school but not actually in the year level and associated with that young person's peer group whose suicide nonetheless has an impact upon the school community as a whole.

CHAIR—In terms of looking at non-Indigenous and Indigenous suicides, is there a difference in contagion?

Ms Ritchie—There is. The RYSQ project looked at 65 suicides in the 2004 to 2007 period, 18 of which suicides were Indigenous. In 50 per cent of the Indigenous suicides, contagion was identified as a factor, compared with 38 per cent in those of non-Indigenous youth.

CHAIR—So the 42 per cent is an average, in other words.

Ms Ritchie—The 42 per cent is the average of the whole 65 considered as part of the project.

Senator BOYCE—Is that peer or familial? Did you break that down any further?

Ms Ritchie—It is a good question. Unfortunately I have not broken the Indigenous and non-Indigenous down for peer and familial. I am happy to do that and forward that information to the Senate if required.

CHAIR—Yes. Do you have a breakdown of the remote deaths versus the city deaths in terms of the contagion issue as well?

Ms Ritchie—I could certainly break that down for you. It is not something we have done at this point, but I am happy to provide those two breakdowns to the Senate.

CHAIR—That would be appreciated, thanks. You were talking about how there are some similarities between non-Indigenous and Indigenous suicides. We know there are some similarities, but then there are differences. So I am interested in looking at how programs are being tailored to deal with the differences.

Ms Ritchie—The Reducing Youth Suicide in Queensland discussion paper is basically our preliminary findings based upon what we know about the 65 children and young people to date. Part 2 of the project will be an even more detailed analysis of the comprehensive breadth of information we have in respect of those children and young people. We are currently entering all of that information into our databases and we will be analysing that in a final report.

Nonetheless, for the purpose of the preliminary analysis we are able to identify some very key differences, which we have outlined at page 7 of our submission to the inquiry and also at page 19 of our ‘Reducing youth suicide Queensland’ discussion paper. I think what these differences highlight is the importance of evidence based and, potentially, in the context of Indigenous communities, place based responses that differ from traditional approaches to the phenomenon of youth suicide generally—that is, it being treated as a whole as opposed to targeted responses for Indigenous versus non-Indigenous. Some of the key differences included that Aboriginal and Torres Strait Islander young people were more likely to threaten suicide in quite an off-the-cuff fashion, with their threats often being the response to a stressful situation, and to follow through. Also Aboriginal and Torres Strait Islander children were far less likely to have diagnosed mental health issues. Suicide notes were also rare for Indigenous youth.

CHAIR—In terms of the diagnosed mental health issue, do you know the detail of whether mental health issues were not involved or it is because they had not—

Ms Ritchie—I think that that is the inherent question. Is it a case that the services were not accessible to them or available? It may have been the case for Indigenous youth. That is exactly right.

CHAIR—Thank you. Sorry, I did not mean to interrupt you.

Ms Ritchie—That is okay. As outlined there, Aboriginal and Torres Strait Islander children are also less likely than non-Indigenous youth to have made previous suicide attempts. So when Indigenous children were threatening suicide they were more likely to follow through with their actions. Aboriginal and Torres Strait Islander children were also three times more likely to have experienced childhood abuse and were more likely to be younger in age at the time they suicided, with the majority of the youth considered as part of the 'Reducing youth suicide Queensland' project—as I said, there were 18 Indigenous youth and 12 of those were aged between 10 and 14 years.

CHAIR—Where to from here? You have obviously done a great deal of work on this issue and you have ongoing programs. What about funding support?

Ms Ritchie—The commission is funded and mandated to undertake a child death review function. We have a team in place, and this is one of the priorities we are progressing in addition to our mandated function to report on all child deaths in Queensland annually. Through the RYSQ discussion paper—I have a hard copy available for you today as we submitted our submission online—we raised a series of questions that we engage with a range of key stakeholders on. We received 235 responses to the discussion points raised through the 'Reducing youth suicide Queensland' paper and we are currently in the process of analysing those. The majority of the questions were qualitative questions, so we are undertaking a thematic analysis, and some of the questions related to collaboration and improving service delivery.

We also asked key stakeholders to identify and provide to us some examples about suicide prevention programs that they were aware of and whether or not they are working and whether they have been evaluated. We are in the process of collating that information. We hope to have a consultation report by around June, which will include some preliminary indicative data from that. The next phase for us then will be to move into identifying what the key issues are. We will be looking at potentially forming some advisory committees with key people in the area to help identify how we translate those issues—based upon what the data is telling us and what we currently know is happening in Queensland—into new pathways for suicide prevention.

Senator BOYCE—If I could follow up on the questions around Indigenous suicide. Are there any distinctions to be made between Aboriginal and Torres Strait youth?

Ms Ritchie—Unfortunately I have only just extracted the data by the whole. I am sorry, I should have thought to have provided that to you.

Senator BOYCE—It is one of my issues—poor old Torres Strait gets lumped in all the time but sometimes this may mask particular differences or cultural variations. The other question was: what has your work shown about suicide clusters?

Ms Ritchie—On page 20 of our discussion paper we provided a detailed overview of what the data showed us in respect of clusters. It was quite interesting. We saw a number of clusters emerging through the data in particular in the Brisbane and Toowoomba regions. For Brisbane, this was perhaps not surprising because we have the largest population of youth. But what was surprising was the Toowoomba region which experienced seven suicides of children and young people in the period 2004-2007. To put that into further context, when expressed as a rate the Toowoomba region in fact had the highest rate overall of youth suicides in Queensland in that time period. The rate in Toowoomba was 44.1 suicides per 100,000 compared with Brisbane, which had a rate of 12 .5. The rate in that area was quite high, with a number of young people attending a particular school suiciding within a very short time of one another, and children who had previously resided in that area and had relocated from the area and were aware of those suicides, also suiciding. We also identified a number of adult suicides in the area as well at that time.

Senator FURNER—Was the school you referred to, where there were seven suicides, a boarding school?

Ms Ritchie—I do not believe so, but I am happy to clarify—

Senator MOORE—What constitutes the Toowoomba region in this context? Once again, it is the regional nature. Is that a state health definition of what the Toowoomba region is—which is wider—or is it particularly the city?

Ms Ritchie—It is specifically Toowoomba—the city.

Senator MOORE—And there is a more work being done in that region generally about that, and that was something that was raised with the whole community.

Ms Ritchie—Based upon our data, we provided some advice to the Queensland Police Service. That was showing them where the suicides were occurring according to Queensland Police regions. The Queensland Police Service was quite concerned, having responded to all of those incidents as well, and it has commenced some quite significant work in that area. They are leading a suicide postvention steering committee and that is focused on developing a coordinated response to the incidence of youth suicide in Queensland. That steering committee has brought together a range of key government and also non-government stakeholders, namely, Independent Schools and Catholic Education, to be part of any coordinated response. Through leading the steering committee, the QPS has secured funding of $100,000 through the Queensland government’s Suicide Prevention Steering Committee, as well as $20,000 in funding as part of a Queensland Police crime prevention funding initiative to pilot the postvention response into areas. Obviously, based on the findings, Toowoomba is the first area, and Mackay is another area that they are looking at.

Senator BOYCE—Is this a statewide steering group looking at statewide issues, or is it in those particular regions?

Ms Ritchie—The steering committee is based in Brisbane and led by the Queensland Police Service. Key representatives from the government agencies such as Education Queensland and Queensland Health are on the steering committee, and representatives from Catholic Education, and Independent Schools, as I said—and I am sure that there are some that I have forgotten—and they are working towards developing the framework for the Queensland Police Service to have this coordinated postvention response as far as youth suicide is concerned. It is very innovative and the Police Service should be commended for the initiative.

Senator BOYCE—I had some personal involvement some years ago with a community around what was perceived to be a high youth suicide rate in Gympie. .Is the commission getting itself involved at the stage when the community is demonstrating concern or are you simply feeding the statistics back into the system?

Ms Ritchie—Yes, we provide the statistics, but I believe through our function we are able to do more than that. We receive very timely notification of a death. We know within 24 hours to 72 hours of a death occurring.

Senator BOYCE—Who notifies you?

Ms Ritchie—The Office of the State Coroner has a statutory obligation to notify us, so by virtue of that timely notification the commission has always been quite proactive if it identifies a trend or pattern in the data. In the context of postvention, to highlight an example, if on the information available in the police report of death the commission has concerns about other children who are identified in that police report—albeit that they located the child or were known to the child in some way—we have actually raised those concerns immediately with the child safety director who sits within our education department in Queensland just in the event that they were not aware that the child or young person had a friend who had suicided, by virtue of the fact that they go to different schools, for example. If we identify any children who may be at risk it is very much about information sharing and acting upon that. So the answer to your question is that if we did identify an issue we would take action proactively if the evidence suggested that some action was warranted on our part.

CHAIR—Do you follow up on that? Do you notify the relevant people? Who follows up on the fact that they took action?

Ms Ritchie—The notification process that we have put in place is at quite a senior executive level, so we do not then monitor what did or did not occur to provide that information to effect action to occur. No, we do not monitor.

CHAIR—That relates to the whole issue around the contagion. If there is a subsequent suicide, is there then checking on whether that child received adequate follow-up services—whether they were notified, whether they actually received support, whether the right postvention measures were effective—so that a learning process goes on as well? Is that part of your approach?

Ms Ritchie—It is not part of our mandate to follow through on what actions do or do not occur. What is inherent in all of this is that it highlights the impetus for a consistent coordinated response to postvention to occur. We are talking to you today from the perspective of children and young people but we know suicide is not confined to children and young people. Whilst the evidence indicates that the manner in which a postvention response is delivered should be different for children and young people to adults, there nonetheless is a need for coordinated postvention at a national level.

CHAIR—Yes. One of the consistent messages we have been getting is the lack of coordination. Is there anywhere where services are being coordinated and where it is ensured that they are delivered?

Ms Ritchie—I am sorry; I cannot answer that question.

Senator ADAMS—Regarding the task force that the police have set up, have they got any consumer groups on that? Are any of the people we had here earlier giving evidence part of that group?

Ms Ritchie—No, it is ostensibly government based, with representation from the two other key stakeholders identified—independent schools and Catholic Education in Queensland.

CHAIR—I have one more question, which I think I can squeeze in before we finish. Both in your submission and in your evidence you referred to the issues around technology and young people. We heard yesterday from the Inspire Foundation and the Reach Out project. Have you had a look at, or are you involved with, any of the projects, particularly their projects, that are being undertaken?

Ms Ritchie—We are not actively involved in projects. I cannot tell you off the top of my head whether they actually made a submission to our Reducing Youth Suicide in Queensland project. As I said we did ask for discussion points about what programs are currently out there for children and young people so that would certainly be something interesting to follow through for us in that context.

CHAIR—They seem very innovative. I have my own personal views on young people, technology and access to the internet in terms of them spending a lot of time there, but I must admit it is a very well-thought-out approach to the use of technology and how they can reach out to young people.

Senator MOORE—To whom does the commission report?

Ms Ritchie—The commission is an independent agency. Our minister is Minister Struthers.

Senator MOORE—So it is community services. When you actually get your final report in this project it will go through her to government?

Ms Ritchie—Yes.

Senator MOORE—Thank you.

CHAIR—Thank you. Your submission and your evidence have been extremely enlightening and useful.

Ms Ritchie—I am glad to hear that and I will get that further information to you.

CHAIR—Thank you. We are going to follow this up in each of the states we go to by the way.

Ms Ritchie—I will be pleased to learn of the outcome.

[2.16 pm]

BARNETT, Miss Leda, Representative, Australian Indigenous Psychologists Association

SCHULTZ, Mr Clinton, Representative, Australian Indigenous Psychologists Association

CHAIR—I welcome the Australian Indigenous Psychologists Association. I understand you have both been given information on parliamentary privilege and the protection of witnesses. We have your submission and we would like to invite either or both of you to make an opening statement and then we will ask you some questions.

Miss Barnett—Firstly we would like to acknowledge the traditional custodians of the land on which this meeting is taking place. They are the Yuggera people and the Turrbal people. As I will be mostly speaking from personal experiences I will give you a bit of history about myself so that you know where I am coming from. I am an Aboriginal woman. My grandmother on my father’s side was a member of the stolen generation. She was taken from her family as a baby and brought up by the Church of England in Townsville. That is Wulgurukabba country up there but we are not entirely sure about her roots in terms of where she was actually from.

I did most of my growing up in Brisbane although I was not born here. We moved around a bit when I was little, so I have lived in a few other communities throughout Queensland. I was born in Maryborough and we lived in Mount Isa for a while. We also lived a few years at Lockhart River and then moved down to Brisbane. In my adult years I have also lived in WA up in Port Hedland and that was for a little under two years. I have come down from Mackay today. I have lived there for nearly two years and it is in Mackay where I have done a lot of my work in relation to Indigenous suicide.

At the moment I am working two part-time jobs. The first job is working on an Indigenous research project on Indigenous suicide. I am employed by the Australian Institute for Suicide Research and Prevention which is located down here in Brisbane at Griffith Uni’s Mount Gravatt campus. The second job I have is as a psychologist intern in a clinical capacity. I am working with clients for the Blue River Health Service.

Senator MOORE—Where did you train?

Miss Barnett—I went to Griffith University.

Senator MOORE—You have come home.

Miss Barnett—Sort of, yes. I consider home to be where my family is and they are all in Mackay at the moment.

Mr Schultz—I think it is also important that I also explain who I am and where I have come from. I am an Indigenous psychologists. I am a member of the Gamillaroy people. My family names are Lamy and Nash and I come from the Lake Keepit, Moree-Tamworth region. This issue is important to me personally because I grew up in the community and experienced the effects of Indigenous suicide on our community and I also witnessed cluster suicides. So I have firsthand knowledge as well as my psychological background to fall back on.

Senator MOORE—Where did you train, Mr Schultz?

Mr Schultz—At Griffith.

Senator MOORE—Kind of a home, then!

Miss Barnett—There are a couple of points that I would like to highlight and then Clinton would like to talk about a couple of points that he would like to highlight. Then we are happy to go straight to questions. I will not really go over anything in the submission, primarily because it is all there, but I would like to highlight the importance of there being no easy answer to Indigenous suicide as an issue. It is of course the end result of a lot of many different protective and risk factors that are at play in someone's life. In response to that, a whole heap of conversations need to happen with communities in an attempt to involve and empower Aboriginal communities. Conversations about making our communities more robust are really important, and these conversations in communities would inform a national strategy that would look at Indigenous suicide throughout the country. In my capacity here, it is important for me to tell you that I will be talking from my personal experiences. I will not be talking on behalf of all the Aboriginal communities in the country or the Torres Strait Islander communities.

Mr Schultz—It is important to highlight the fact that suicide behaviour and risk factors for suicide in the Aboriginal and Torres Strait Islander communities cannot be seen in the same capacity as non-Indigenous communities or populations due to the added risk factors that are there for Aboriginal and Torres Strait Islanders, like loss of culture, disconnection from land, family, racism and prejudice, and previous policies of segregation and assimilation, as well as all the well-known risk factors to suicide. My area of expertise on this would be cultural competence and the importance of cultural competence for practitioners dealing with suicide in Indigenous communities. As important as it is for suicide awareness and suicide education to take place, I do not believe that the education and the awareness is likely to have an impact in the community, basically because there is not the professional capacity or the cultural competence in the regional and remote communities at present to deal with people who are identified as being at risk.

Senator MOORE—We will go straight to that because it is a really important aspect and it is mentioned in your submission. In terms of the number of Aboriginal psychologists, that has not been mentioned in your submission.

Mr Schultz—At present, AIPA—the Australian Indigenous Psychologists Association—we have 40 registered members.

Senator MOORE—Across the country.

Mr Schultz—Yes. To be better represented in the community, we are looking at needing at least 200 to just have a reasonable representation compared to our population in the country.

Senator BOYCE—Would the vast majority of Indigenous psychologists be members of your association?

Mr Schultz—Yes. There are a few coming through universities at present, but there are only 40 of us registered with AIPA at present.

Miss Barnett—Having said that, it is also a fairly new association, so the word is still getting out there about its existence and to encourage others to enrol.

Senator MOORE—Your profession does tend to get the word out very quickly. It is one of those that do talk to each other a lot. Certainly all people who identify as psychologists would not necessarily be treating clients who identify as needing your help—that would be a given—but there would certainly be an added incentive in some ways, I would imagine, if you are working in your field, considering the amount of evidence that there is a need for people to try and practice in areas.

Mr Schultz—I think that is one of the downfalls at present, that when students are completing university and going out for their first jobs in psychology they generally are getting pushed out to these sort of regional and rural areas because that is where you are going to get offered work basically. They are going through and they are not adding that cultural confidence behind them to engage with the Indigenous populations of the areas they are being sent to.

CHAIR—You are talking about non-Indigenous.

Mr Schultz—Non-Indigenous psychologists who are coming through and then being expected—

Senator MOORE—To go where the jobs are.

Mr Schultz—Yes, being expected to interact with Indigenous populations without any of that training or cultural awareness or competence.

Senator BOYCE—And just being a new graduate as well.

CHAIR—In terms of the burnout rate and when that happens, even assuming the cultural competence, if you are a relatively new graduate and you are going out and you have not had much involvement it must be pretty overwhelming for people if they do not have support in terms of just the issues they are dealing with.

Mr Schultz—I am not presently aware of the figures on that. I am about to start a study on institutional racism and its impacts on new psychologists going to work out in a community. Hopefully I will have that information by midyear.

Senator BOYCE—Is that a doctorate?

Mr Schultz—It is just a paper that I am formulating for the International Congress of Applied Psychology in July.

Senator MOORE—You actually mentioned, Ms Barnett, and the submission says that there should be a separate stream of strategy at the national level, particularly areas of Aboriginal and Indigenous need. Has your organisation raised that with the government in terms of why that would be a good idea?

Miss Barnett—Apart from what they have actually written in the submission, I think it is in the process of being done.

Senator MOORE—In the mix. You almost need a whiteboard to understand all the various organisations and a flowchart to see how they work, and you fall into the acronyms. Certainly it seems to me that within the scope of the current plan there is acknowledgement that there needs to be particular focus. As you keep saying in the submission, there is an acknowledgement that there is need but you recommend more than that; you actually think there needs to be a completely separate strategy which acknowledges the issues rather than being tacked on to the mainstream.

Miss Barnett—Absolutely.

Senator MOORE—What could be the benefit of that, for the record? To get that out there would be really useful.

Miss Barnett—That is my view on a lot of things I have seen done over time. Usually it is a national strategy for the Australian population and then perhaps an appendage of some kind for the Indigenous population. I think it would be better to have strategies that are specific for Indigenous populations and perhaps even a strategy for Aboriginal people and a strategy for Torres Strait Islanders, separate ones. I think the benefits of that are because the contexts are so different, the contexts of non-Indigenous Australians and Aboriginal Australians and Torres Strait Islanders. In my experience in the research that I have done over the past few years, and not just with the suicide project that I am currently working on but research that I have done in the past, I continue to be pleasantly surprised with regard to the diversity within our Aboriginal culture and from what I see within Torres Strait Islander culture. There are differences between urban, regional and remote and rural areas, and where you consider the geographical location of course each community has a different history, it all has a different context. I believe that communities have answers to their own issues, but I do not see an opportunity for them to be empowered or for them to be provided the resources they need to engage in strategies that they know are going to work for them. So, when we talk about a national strategy, I think an important aspect of that is for it to be grassroots-led. Rather than top-down, it should be more bottom-up.

Senator MOORE—This morning we heard from BoysTown, and when you have a look at the *Hansard* you will see that they talked particularly about a project they have going between Balgo and Logan. It was particularly mentioned by the person who was giving evidence that there was a major difference between the young people from those two areas, and it took a while. There was a real difference between them, yet, under the strategy, possibly the only difference that would be noted would be that one is remote and one is metropolitan; that would be it. But he was making the point that there was significant difference culturally between two groups.

Miss Barnett—Absolutely.

Senator MOORE—Lots of people have questions. If there is more time at the end, I will come back.

Senator ADAMS—Thank you both for your submission. I would like to talk to you about the programs. You have the Yarrabah Life Promotion Program and also the Yorgum Family Counselling Service in WA. Could you explain how they work, because we are really looking for things that work on the ground.

Miss Barnett—Okay. I will talk more about the Yarrabah rather than the Yorgum, because I am more familiar with the Yarrabah model. The Yarrabah model is probably a fantastic example of what I was talking about in terms of a strategy that is developed by a community at a grassroots level and that addresses an issue in the community. It is a perfect example of a community with the answer who were enabled to do what they needed to do to address the issue. They adopted the ‘life promotion’ title rather than having a title with the word ‘suicide’ or something like that in it, for obvious reasons. That has been quite successful over a number of years, although I have heard that, with time, resources have dwindled and, where there is a community need for such a program, a lot is happening on minimal resources.

Senator ADAMS—Who took carriage of it? How did it start?

Miss Barnett—How did it start?

Senator ADAMS—Who was the leader? Were they women? Were they elders of the community? How did it all start?

Miss Barnett—They had a significant number of suicides in the community. It basically came about as a result of the community’s grief and distress with regard to not really being able to do what they felt needed to be done to address suicide in that community. So it was community initiated. The dynamics of the community are usually that elders are the instigators. They are the ones who are knowledgeable, so they are the ones who take control, so to speak. Women certainly have a very significant role in all of the Aboriginal communities I have been to. But it is pretty much a community job, so everyone gets in and does what they feel they can do with regard to that. I am not actually an expert with regard to how it has run over time.

Senator ADAMS—That was really what I was looking for. But, anyway, thanks for that. And the WA programs?

Senator FURNER—I will jump in on Yarrabah, because I have some questions around that as well. You could hardly call Yarrabah remote, because it is not that far from Cairns. Was it a case of a lack of services in Cairns itself? Was that one of the triggers for why there was a need to introduce such a program?

Miss Barnett—That issue is not actually unique to Yarrabah. Accessibility is a huge issue. I have certainly witnessed it in my personal experiences.

Senator BOYCE—I still do not understand why there is not a ferry from Yarrabah to Cairns.

Miss Barnett—You were asking the lady that was talking before me, for the commission, about the differences between regional and remote and the statistics. One of the things that came to mind when she was talking was accessibility to health services and how big an issue that is. When she was talking about young people, that is even more so.

CHAIR—My experience from WA is that accessibility is not just about regional and remote either; it is about access to services in the cities as well.

Miss Barnett—Absolutely.

Mr Schultz—A culturally appropriate service.

CHAIR—That is what I mean.

Senator BOYCE—Some of us may feel we know the answer to this question, but could you talk a little bit about Indigenous cultural attitudes to suicide that might differ from non-Indigenous attitudes and differences between Indigenous communities in their attitudes to suicide?

Mr Schultz—To start off, it is good that you acknowledge that there are those differences between the communities—so they are all going to have their individual opinions on suicide, its causes, its risks and all that.

Senator BOYCE—Stigma or lack of—that sort of thing—is what I am trying to get to.

Mr Schultz—In the communities that I have worked on and lived on, there has been, especially amongst young people, almost a ‘martyr’ opinion. Suicide can at times amongst the young people be a way of getting back at the system which they feel is so unjust.

Senator BOYCE—‘I showed them.’

Mr Schultz—Basically, yes. It is very influential amongst the community. I guess the biggest difference between Indigenous peoples and non-Indigenous peoples in Australia is that Westernised society is very individualistic—it is about yourself and your immediate family—whereas the Indigenous community is more communitarian, so your community comes first and then it is your family and then it is yourself. If something happens in the community, it spreads throughout that community very quickly because everybody is so connected and does care about the community. If there is a suicide in a community, that impacts on everybody in the community, which then has that flow-on effect of constant grief, constant loss, without the services to deal with that, which then can lead to the formation of clusters.

Senator BOYCE—Is it, within any age group, seen as an acceptable solution, an ‘out’? There would be blocks of non-Indigenous younger people who might think that it is okay.

Miss Barnett—Two of the questions that I asked the participants in the study that I was doing were: ‘Is it acceptable?’ and ‘Is it understandable?’ I was talking in relation to someone taking their life. The majority of people said, no, it was not acceptable. As for understandable, there were a few people who indicated that they could understand someone choosing to take their life, given the circumstances of their life and the situation that they were in.

Mr Schultz—Another thing we have to realise there is that suicide was not something that was really known amongst Indigenous societies up until maybe 40 or 50 years ago. It is only in the last 20 or 30 years that it has actually become prevalent and become a problem.

Miss Barnett—I would argue that in Indigenous communities there is a different sense of despair. I think that would be due to the unlevel playing field for health, education, employment and all of those other aspects of social and emotional wellbeing.

CHAIR—We were in the Northern Territory the week before last, at a hearing. One of the witnesses was talking to us about trauma and their experience in communities in the project the particular person was running. They said that the average number of traumas a person in a community had experienced in their lives was 12, and that included the death of close family members. That must have an enormous impact on people’s despair, then you layer on top of that intergenerational trauma as well as their lived trauma. There must be a huge impact that would for a start, to me, make it necessary to point in the direction of a separate strategy to deal with it.

Miss Barnett—From what you are saying, Senator, it seems to me that you have an understanding of what I am saying when I talk about a different context for Indigenous communities and even between different communities.

Mr Schultz—When you do have that level of trauma, as we were saying earlier, there are not the services to provide professional assistance even when those people are identified as being at risk. There are not the services for them to be referred off in many of the regional and remote areas.

Senator BOYCE—That brings up another point where I wanted to try and put two things beside each other. You talked about bottom-up and community-led solution but the fact that there was not sufficient expertise to deal with mental health issues in rural and remote and probably urban as well. How do those two match up?

Mr Schultz—At present they do not at all.

Senator BOYCE—Can you have a community-led program that is also requires outside expertise? Where do you see that outside expertise fitting into something that a community has developed?

Miss Barnett—I can see that work. That is the short answer to the question. I think a lot has to happen before it actually works. Like I said before, there needs to be a lot of conversation with community with regard to what they think the answer is. When you are talking about experts from outside the community coming into work with the community it is a very time-consuming process. If you do it right and if you do it properly it is very time consuming and it is very resource consuming and it is very emotional as well. These outsiders actually need to invest in interpersonal relationships with community people. I think that is what it is all about. Communities are not really going to know that people outside the community care unless they actually know the community, know the community members and know what that community is all about.

Senator FURNER—I want to know what your exposure is or has been with deaths in custody?

Mr Schultz—Throughout university I did a little bit of research on the whole deaths in custody matter. I think the major issue with deaths in custody at present is duty of care and the issue of alcohol dependency and withdrawal. So when people are being picked up for alcohol related issues then placed in custody, who is responsible for that person and is sufficient duty of care being offered to that person? I do not think deaths in custody should be occurring if somebody is getting the supervision that they require. I think it should be noted that a lot of these people who are getting locked up for alcohol related issues may have a life history of alcohol dependence. So once locked up they have to face all the withdrawal systems, the same that anybody else who is alcohol or drug dependent has to face. Those people have to go through those same withdrawal symptoms, and I do not think they are being provided with the means to appropriately go through that period.

Miss Barnett—I think it is important to also consider the fact that, like I said before, suicide is the end result. So, of course, a lot has to happen with regard to the social and emotional wellbeing of anyone in custody before they even get there.

Senator FURNER—You did hear earlier about our involvement a couple of weeks ago at a hearing inquiry in both Darwin and Alice Springs. There was a lot of evidence about hearing impairment amongst Indigenous populations to the extent where it is considered that they are being wrongfully accused at times. Have you drawn any parallels between those sorts of impairments and the likelihood of suicide attempts at all?

Mr Schultz—I have not personally seen any studies comparing those two issues, but I can see that it could be probable that a connection exists there. We are such a linguistic society and rely so much on the English language that, if you are someone who is hearing impaired or speech impaired, you are often misunderstood. Sometimes that can lead to further dramas such as being accused of being drunk or something like that when in fact you cannot speak properly. This can then have a flow-on effect of your having lowered self-esteem, low motivation and depression—all those sorts of things—and then, I guess, becoming stuck in the cycle.

Senator FURNER—Are there programs available whereby you are able to visit Indigenous people who are in prison to establish whether they might be dealing with any psychological problems?

Miss Barnett—That is a good question. I know of primarily elders' groups and church groups that visit those of our mob who are in prison. I do not know of any psychologists who visit, other than those who are employed by Corrective Services.

Mr Schultz—I definitely do not think there are any Indigenous-specific psychologists who are going through, because, basically, there are not the numbers in the country to service everybody's needs at present.

Senator BOYCE—Or the jobs in the government.

Mr Schultz—Yes.

CHAIR—Before I handover to Senator Boyce, I would like to follow up on the issues of social and emotional wellbeing in programs. Yesterday, I heard of a program in Western Australia that is supposed to be good. It was highly recommended. What programs do you know of that deal with this overall issue of social and emotional wellbeing for Aboriginal communities?

Mr Schultz—My job with the Kalwun Aboriginal health service on the Gold Coast is to run a health service. In conjunction with that, I do a lot of health education and counselling. I also attend the men’s groups that are in the area. From my point of view, social and emotional wellbeing is definitely being attended to in my area by having such things as Aboriginal men’s groups and women’s groups, which the elders attend and the kids or the youth can come along and hear what they have to say. There is that community involvement.

CHAIR—How is that funded? I know of the two programs that you recommend in your submission, but I am looking at the sorts of things that you have just talked about, although maybe not such formal programs but they are accomplishing the same thing.

Mr Schultz—In my area, different groups are run by the different Aboriginal organisations in the area. So it might be Kalwun, it might be Krurungal or it might be any of the other organisations. I think Queensland Health and Australian Indigenous Health run a program down there as well. The ones that are run by the community-owned Aboriginal organisations are pretty much reliant on outside funding. They are usually not-for-profit organisation, and so they are reliant on different government funding and stuff like that. Sometimes organisations such as beyondblue might be able to offer some assistance. However, they are generally reliant on government funding.

CHAIR—Do you have any experience with the Divisions of General Practice and the programs that they are supposed to be running for community health?

Mr Schultz—Yes. My job with Kalwun is actually through General Practice Gold Coast, GPGC. They offered the funding to Kalwun and Krurungal, in a partnership with Queensland Health, which then led to my being employed to implement a health promotion program. At the moment, they are not looking so much at suicide prevention in my area; they are looking more at things like obesity, chronic disease and chronic illness. There is not enough emphasis being put on—

CHAIR—Health promotion.

Mr Schultz—mental health or social and emotional wellbeing.

Senator BOYCE—How long has that project being going for?

Mr Schultz—It has been running for four weeks.

Senator BOYCE—You are not finished yet!

Mr Schultz—No. The initial program is a 12-week program. Participants will go through for another eight weeks, and then we will see what happens. Hopefully, we can get ongoing funding.

Senator BOYCE—Can you tell us a little bit more about the men’s and women’s groups that are functioning on the Gold Coast? How long have they been going for? How sustainable are they?

Mr Schultz—I can only talk about the men’s groups. I cannot talk about the women’s groups at all. I have no involvement in women’s business whatsoever. Kalwun Health Service has been running the men’s group for about 12 or 18 months. At some stage, one of the organisations, be it Krurungal or Kalwun, will get a men’s group up and running. As I said before, they are reliant on funding from Kalwun or Krurungal for whatever activities they undertake or any resources they need. Kalwun and Krurungal and organisations like them are then reliant on funding, say, from government organisations.

Senator BOYCE—These groups exist because Kalwun initiated them?

Mr Schultz—Most of them come up through community-owned Aboriginal organisations and, in some areas, land councils.

Miss Barnett—Can I just add something. I think an important aspect of that is also finding the staff to do it. What Clinton did not share with you—and I hope you do not mind me saying this, Clinton—

Senator BOYCE—He does this in his spare time.

Miss Barnett—is that they pretty much pounced on him as soon as he was available to do something. It was just sheer luck on their part that they were able to hire him to do it. From my observation—I have actually seen this happen in Mackay—it goes with the staff. We, too, have men’s groups and women’s groups happening up there. But, depending on where the staff who initiated the group go, what they have done goes with them. Should they change employers or what-have-you, the relationships that they have established usually go with them. What happens is that things like the women’s groups or the men’s groups go to the other organisation as well.

Senator BOYCE—So they get restarted—the waves and troughs type of thing? I guess all volunteer organisations tend to do that sort of thing.

Miss Barnett—Somewhat. But what I have noticed is that, because the community members have relationships with the coordinators of these programs—

Senator BOYCE—So they move to another service provider in town?

Miss Barnett—That is right. It is in the best interests of a service provider to hire somebody who has that experience, because those community members will then be exposed to another service that is available in the community. Because those relationships have already been established, it is easier.

CHAIR—It is like a plug-in model. You do not have to do that development work.

Senator BOYCE—Just going back to the evidence that we had from the Queensland commissioner for children in relation to adolescent death, I do not know whether you saw the list of things which distinguished Indigenous youth suicide from non-Indigenous youth suicide. For instance, Indigenous youth announce their intention in a more off-the-cuff way and go ahead with it et cetera. Are you able to comment on those findings and perhaps give us some sense of what needs to happen to change that?

Miss Barnett—Okay. Senator Boyce, I will talk about my experience of working with young people. When I started working as a clinician in Mackay, my first experience in that capacity was responding to suicides in the community. It was a very steep learning curve for me. I noticed that these young people who ended their lives were not engaged in any kind of service in the community. They were not engaged with mental health. They were not engaged with school. They had no connectedness in that respect. They were my observations. I did not know these young people, but that is what I observed.

Senator BOYCE—I suppose there are a thousand things that we could be doing, but is there anything specific that would assist in what seems to be a quite different way of going about suicide in the Indigenous community? I realise this is difficult to talk about, but I do not know how we fix it without talking about it?

Mr Schultz—I think that comes from both ends. As psychologists, on our side there needs to be more cultural competence training. More Indigenous psychologists need to make it through university. There needs to be more support for Indigenous students who are going into psychology and coming through so that there is that access—or increased access—to culturally appropriate mental health services.

Miss Barnett—Anything to prevent suicide really needs to happen in utero. I think there are a lot of factors at play before a child is even born that feed that child’s development and resilience, and the resources that are available to them and what they are exposed to in their immediate environment.

Mr Schultz—There is definitely a need for a national strategy as we have mentioned before that is separate to non-Indigenous populations, but it has to be developed so it can be used cross-community. None of the communities in Australia are the same, so it needs to be developed so it is transferable, transparent and can be used across communities. I think the best way to do that, as Leda was saying before, is to engage communities first. Identify the problems in individual communities because the problems are going to be separate in each community. Once they are identified and the community is aware, they can come up with what they think is an appropriate response and it can be taken to a regional level. It is more likely that close regions or communities are going to have similar issues before it can be taken to a national type plan or strategy.

Senator BOYCE—You are talking about this more as a wellbeing program rather than a suicide prevention program.

Mr Schultz—Social and emotional wellbeing.

Senator MOORE—We heard yesterday about a conference that was held in Western Australia last year. It got a fair bit of public focus about concern in Aboriginal communities about what was happening and their future. Are you aware of that—and I forget the name of it; can someone help me with the name of the community? It was mentioned three times yesterday. I apologise but it was one which focused quite exclusively on Aboriginal communities and how people look at health and wellbeing, and looking at the issues of suicide. Are either of you aware of that process?

Miss Barnett—No, I am not.

Senator MOORE—I think it was called the Black Page—I will get it from the *Hansard* yesterday; I just haven't got the submissions from yesterday. It was mentioned a fair bit. It was raising the same issues about community focus bottom-up; all those things. I am waiting to see whether they have come up with a recommendation for a totally separate strategy. I think the structure of our services now indicates that that could well happen in that we have the Department of Health and Ageing who have the focus on the plans and the advisory committee to the minister but we also have another minister who is responsible for Aboriginal and regional health. There is almost a window there that you could use that.

Senator MOORE—Billard conference—it is something that you may want to check out because it has been getting a fair bit of link now. At least one of the women involved in pulling that together is now in New York representing Australia at the Beijing + 15 looking particularly at these issues around communities.

CHAIR—I have got a couple of follow-up questions. One is picking up on your issue about more Aboriginal psychologists: is the association working with our tertiary institutions to work out how to encourage more Aboriginal students into psychology; how to support them?

Mr Schultz—As we mentioned earlier, AIPA was only formed recently, so we have not had a chance to delve into a lot of issues at present. The main focus of AIPA has been on trying to design a cultural competence package to be delivered to practising psychologists and students who are coming through psychology. That is where the focus has been to date.

CHAIR—You just pre-empted my next question around cultural competence—sorry, I did not mean to interrupt you. Once you have done that you will then go onto other things.

Mr Schultz—It was raised. We had a meeting in Darwin at the end of last year. One of the points raised was: how do we get more students to, firstly, come through into psychology and, secondly, then maintain them. It was raised and it was on the agenda of things that need to be looked at.

CHAIR—In terms of the cultural confidence issues you are developing a package. Do you then expect to take that to the universities. Ideally it would be good to get it before they come out of university. It would be good to get it as part of the coursework.

Mr Schultz—I think at present the greatest issue there is that, as the universities all have such self-control over what they implement in their courses, it is unlikely that all the universities are going to take on a single package because they like to have their individual approaches to subject material. At the moment we are in talks with the School of Psychology at Griffith and trying to help them develop a cultural confidence package for their students.

Miss Barnett—They have plans to ‘Indigenise’ if you like the curriculum they have.

Senator BOYCE—That would then attract more people, so it becomes a centre of expertise.

Senator MOORE—Particularly when they have the centre for research on suicide at Griffith at the moment, it would seem to be a really good synergy to get that going. We will see how you go.

CHAIR—Thank you very much for both your submission and your presence today; it is very much appreciated.

Miss Barnett—Thank you very much for the opportunity. We both really appreciate it and I know that our colleagues at AIPA do as well.

Proceedings suspended from 3.01 pm to 3.15 pm

MARTIN, Professor Graham Edward Douglas AOM, Private capacity

CHAIR—Good afternoon and thank you for coming. I understand you have been given information on parliamentary privilege and the protection of witnesses and evidence.

Prof. Martin—I have.

CHAIR—We have your submission. I invite you to make an opening statement and then I will set them all off asking questions.

Prof. Martin—Thank you for the opportunity to be here today. Firstly, I am a professor of child psychiatry at the University of Queensland and I have a long history in suicide prevention. I am representing Suicide Prevention Studies, which is a group of researchers at the University of Queensland. Yesterday I reviewed my written responses to the inquiry’s terms of reference. Because I have had the opportunity to respond formally through several other channels, my responses appear intensely personal and perhaps a little idiosyncratic. I need to restate some issues to help make sense of what I wrote in November. I believe the Australian National Suicide Prevention Strategy has been a success. You must remember that our strategy targeted young adults for the first five years from 1995. For young males pre strategy there had been an overall increase in rates per annum of 3.3 per cent—let me restate that: an increase of 3.3 per cent in the years leading up to the strategy.

Following the strategy there was a reversal to an average sustained decrease of 5.4 per cent per annum. That has been sustained. That even takes into account the high in 1997. You will realise that our strategy started in 1995, but there was a peak in suicides in males in 1997. The pattern is similar for young females, though not reaching statistical significance. For all-age males, the increase in the rate pre strategy was one per cent, but since 1995 it has shown an average decline of 2.3 per cent per annum. The effect is not discernible for all-age females. I suspect that in part the story is that for women there are not enough suicides for it to reach any statistical significance. I do not think that it is some kind of artefact of the science that we have been involved in.

I flagged in my submission that there was a national suicide prevention strategy comparison—an international one—that I have completed. I would now like to table that. I extracted some pages on the area of Australia, and I think you have those in my submission, but these are where the facts come from. You might enjoy the full submission.

CHAIR—Thank you.

Prof. Martin—If we look at the other four international strategies, Finland, Norway, Sweden and New Zealand, that are, like our strategy, over 10 years old, for at least three we can perceive similar trends. Rates go up and then there is a strategy, and then rates fall. This is true for all of those countries and it was fairly dramatic for New Zealand. For Sweden the rate just continued to fall post the strategy. They had a falling rate anyway and it has continued to fall. That might sound unremarkable except that you have to remember that it is against a backdrop of climbing rates internationally. If you look at the World Health Organisation figures for suicide, they are absolutely trending upward and yet you have five countries with long-term strategies that have lowered rates.

These five—and I will call them this—successful, long-term strategies have several elements that appear to be important. They are truly national—that probably needs some explanation; they have clearly stated goals; they trained large numbers of professionals to ensure clinical responsiveness; the general public awareness campaign for each was broad and ongoing, which has led to increased help-seeking by the community; and all of the strategies targeted grieving survivors. There are many more similarities that you can draw out, and those are drawn out in the larger document.

The model of prevention we adopted in Australia, which was essentially that of Mrazek and Haggerty in 1994—and this was probably not really adopted during the youth strategy, only when we got to 2000 and were writing the life strategy—had two broad aspects: improving clinical responsiveness and care, on the one hand, and considering how we could intervene earlier in the pathways to suicide for individuals, for groups at risk and at the population level. Within this we targeted mainly risks, and that is because the literature on suicide has been mainly about risks and preventing risks. I think we struggled with how to improve protective factors. These have only come onto the scene in scientific research for perhaps 15 years—perhaps a little longer than that—and one of the problems is that they are very hard to operationalise.

For instance, if you talk about social and emotional well-being, as you did with our colleagues from Aboriginal communities, when you come down to it it is actually quite hard to define exactly what we mean by that. We can use a range of terms which get us close, but it is actually quite hard to say, ‘That is it. That’s the target. That’s what we’re going to aim to reach.’ If you use another word, like ‘resilience’, for instance—actually, it is arguable exactly what resilience is—we have that problem again; whereas, if you take a risk like, say, depression, which is the major risk factor for suicide, it is very clear and the diagnostic and statistical manual has laid it out for us in operationalised terms. Although we adopted this twin approach, we actually struggled to introduce mental health promotion or the development of increased or improved protective factors. These two broad aspects, clinical approaches versus early preventative approaches, are particularly poignant in Indigenous communities where it will always be difficult to have sufficient and appropriate clinical resources—we have just been hearing about that—and where we have not yet fully understood how to reduce risks and increase protections. Our study of social and emotional well-being and suicide prevention goes some way to address some of these issues, but we have still struggled. I understand you may have a copy of that. I think it was part of the original submission. If not, I flagged it in my submission.

Senator BOYCE—Is that *Identity, voice place*?

Prof. Martin—That is the one. I believe that we have done well in Australia, but there is still much to be done—for instance, maintaining public awareness. You just cannot have one campaign and expect that that is going to do the job. As people grow and develop, you need repeated campaigns over time to maintain the level of public awareness about what to look for, how to protect people and how to find services. There are still many clinical service issues to be addressed. Having been a paraplegic for several weeks around Christmas and New Year, I can tell you from personal experience of some of the vast array of problems in the ordinary health system that I suspect—and, in fact, I have had some experience to suggest—are magnified in the mental health system.

There are still hidden groups at risk. I just picked out one of those in my submission, and that was that we highlighted self-injurers. We had completed a very large national survey of 12,000 subjects. Again, you will probably not recognise the butterfly, but this is something that you have probably seen. It is in fact on the Commonwealth site. Again, I will leave it here in case it has not been seen.

Let me just pick up on a final thing which I flagged but did not have to hand, and I had to seek permissions. There has been, and I am sure you are well aware of this, lot of argument about whether or not there has been a decline in suicide rates in Australia, in particular around 2002-03 when there were some misclassifications. It looked like we were probably wrong and perhaps we had overstated the case for our success. Many people have said that. What we did—that is, Andrew Page, Richard Taylor and I; the other two people have been heavily involved in programs and, in fact, Andrew Page put in a separate submission on behalf of that team—was look at recent declines in Australian male suicide and a very close look at whether we could define whether any misclassification had an impact on the rates. I will leave you with this document. I have a graph which demonstrates, even from a distance, that even if you take a three per cent misclassification, an eight per cent misclassification or a 17 per cent misclassification, the graph is still going down. So, I would reiterate that, despite all of the problems of the strategy, I believe we have actually been quite successful, and by comparison with other countries across the world we have been more than successful. I think that is a defensible statement.

Senator MOORE—We have had a range of evidence about the failings of the system. I do not think it is necessarily an attack on the system so much as an intent to try and make it better. I think if it was portrayed as just fighting those people who think the success has been there it would not move forward. I am sure that the people who have submitted to this inquiry, those who gave evidence yesterday and those who will do so in the future, are dedicated to trying to ensure that we do better. The major flaws that have been identified by the people who were seeking change seem to revolve around data, coordination of services and access to services. That is my definition. Other people may disagree but the kind of evidence we had yesterday fell into those three categories. I think that even though your submission talks about the fact that the figures have gone down, those three elements could still remain in terms of the discussion.

I would very much like to talk with you about your views on coordination, which seems to be a big issue. We have funded suicide strategies and suicide actions in the country for over 10 years—and beyond that as well; but there has been a feal focus in the last 10 years—but there still seems to be a view that there is little coordination and that, in terms of extended long-term planning that is not really happening to the best we are able. Are those statements with which you can agree?

Prof. Martin—Yes, I do.

Senator MOORE—Do you have any suggestion, with all the work you have done, for ways that we could better coordinate? Who should do it? I think the big issue comes down to who should do it.

Prof. Martin—I suppose what interests me is that the Commonwealth—the Australian government—set themselves up, in a sense, by developing a national strategy, which, as I hope I stated clearly, in part depends on clinical services.

Senator MOORE—Absolutely.

Prof. Martin—The majority of the clinical services are, of course, run by the states. If you do not have a good dialogue with the states then you cannot get the agreement that is necessary to clear up some of the obvious problems that exist in clinical services. We talked about that at a very high level four, five, six years ago and I think since the COAG process occurred there have been some improvements. My understanding is that many of the states are now beginning to accept that basis of the national strategy on which to build, for their own states, and alter accordingly.

But the Commonwealth cannot actually tell the states to solve the problem of emergency departments who stigmatise suicidal or self-harming individuals. That is for the states to organise. I think it has been very complex to think their way through that. I have now had experience of two lots of state committees and it has been very difficult, even at the state level, to work out exactly how to solve those problems. So often there has been some kind of initial attempt to fact find, and then it has all been too hard. Somehow the dollars have been spent and the real change does not occur, or the training that is necessary does not occur.

The other thing is that I find it rather quaint that the state committees do not have somebody from the Commonwealth sitting on their committees at a routine level so that there is a kind of dialogue. I will quote an instance from about four or five years ago. Several programs in Far North Queensland were funded by the Commonwealth but nobody at the state level seemed to know much about them—what they were doing or how they were working. So there was then duplication, or attempts at duplication. Of course, the communities themselves became extremely confused about two groups trying to run slightly different programs there.

Who should ultimately run it? My own view is probably fairly harsh on the states. That is, I suspect that if suicide prevention is left to the states it will be frittered away. There are very large lobbies to re-absorb suicide into the mental health agenda, to subsume it in the mental health agenda, and it will get lost as an issue. So you do need something at the national level. I have been on most of the national committees at one time or another and they have worked as hard as they possibly can to identify the issues and to make sure they were presented to the government, to DoHA. Most of that has been reasonably good.

As you will know, I was removed from the committee because there were two adolescent psychiatrists, and Michael Dudley is just as good as I am. What they did then quietly was to make me national adviser, which I thought was very nice of them; it has been a very limited role. What they have done really rather nicely is to make the committee structure directly reportable to the minister. That makes eminent sense for me and there is likely to be improvement. I happen to know the chair of the committee. He is very direct, he has some very good ideas and he has represented the issues to the minister very well.

Senator MOORE—That is, for suicide prevention.

Prof. Martin—Yes.

Senator MOORE—One of the questions we asked yesterday of the department was: what is the interaction between the national advisory group on mental health and the national advisory group on suicide? I think the answer was they have one joint member.

CHAIR—That was the answer.

Senator ADAMS—But we have to follow up on that, because you are sworn to secrecy on one committee, and I guess she is sworn to secrecy on both. So how do they interact? But that was the answer.

Senator MOORE—We have to check the *Hansard*. I do not want to be flippant, but I think that was the answer.

Senator ADAMS—It was.

Senator MOORE—Throughout the evidence we have heard there has been great acknowledgement that the work on the national mental health plan and our services to mental health really link in with any suicide strategy. Everyone is very clear that suicide is not always linked to a mental health issue but that people cover both bases. But your view is that very clearly the suicide agenda should be maintained as a separate plan.

Prof. Martin—My view is that before we had identifiable suicide prevention activities there was nothing. My great fear would be that we go back to that, because the mental health agenda is very hungry. You can argue, for instance, that, if you train people around the issue of antidepressants, if you increase antidepressants prescribing and if you put your dollars into that kind of process, that is going to have an impact on suicide prevention. In fact, if you look at the international literature, there are examples of what looks as though that might be the case, except, interestingly enough, in most of the examples there was already a reduction going on in suicide before the antidepressant rate was rapidly increased. So we still have doubts as to whether increasing antidepressants is going to do the trick. Most mental health practitioners, most psychiatrists, would argue that all you have to do is to diagnose depression properly and—I am obviously being fatuous—increase antidepressants. I am being a bit naughty, but I worry that it will get watered down by other forces.

Senator MOORE—You heard the previous evidence, where there was an argument made very strongly to have a separate Aboriginal and Torres Strait Islander strategy, as opposed to it being a subset of the national strategy. Having read your submission, I know you are very interested in that area. Do you have a view on that?

Prof. Martin—If we are going to make genuine progress in this area, that is a very useful strategy. I can see that it would be enormously problematic, in that communities would find a new area over which to fight. That is always going to go on, but unless we address Aboriginal issues from an Aboriginal perspective, with assistance, we actually are not going to make that much progress. If you look at, for instance, the number of Aboriginal deaths in Queensland, they are still three times the rate that they should be.

Senator BOYCE—Before we move off the coding and data, you mention in your submission having been involved in a Royal Australian and New Zealand College of Psychiatrists statement. You state that it is clear that there need to be ‘accurate descriptions about what is and what is not a suicide’. Could you tell us whether your views on that topic differ from those of, say, the children’s commissioner, who felt that it was quite easy to use the international classification?

Prof. Martin—It should be quite easy to use the international classification but, on the other hand, we had serious problems in 2002-03, when there were a large number of accidental overdoses which in fact should have been defined as suicide. Whilst the ICD is reasonably accurate and reasonably easy to follow, I think we need to be very clear about what is suicide and what is not. Of course, the issue there is one of intent as much as anything. Had this person flagged or written something down telling us that they were going to suicide? Of course, coroners are loath to make a decision on suicide unless they have got that kind of evidence. Only 15 to 20 per cent leave some kind of note. Probably less than 50 per cent would actually tell somebody, even in an offhand kind of way. So it is difficult for coroners, and I would accept that it is very difficult for them.

I suppose I would accept what I think other countries have accepted—that is, if we are not clear then we need to put it into ‘unclassified’ and accept that we will always have an unclassified rate that will exist, and it does not matter. As long as we are looking over the years and we are using the same criteria, we should be able to tell whether a strategy is successful or not. My understanding is that in Australia we have done quite well with our nonclassified or misclassifications. We have actually got rates that are lower than those in the UK, Scotland and a number of other countries. So I simply think that we need to have a very clear decision about how we make those judgments and if we cannot do it then we must accept that a certain percentage will always be unclassified.

Senator BOYCE—And that does not matter as long as you are monitoring the level of unclassified?

Prof. Martin—Absolutely.

Senator BOYCE—I also wanted to ask you if you would talk a little bit more about the information you have given us here regarding self-harm. This has not been raised as a particular issue with the committee with any force before. Could you tell us about this particular group? In fact, it is an extra focus that you are suggesting here?

Prof. Martin—It is an extra-special focus, yes. Simply put, 53 per cent of self-injurers had attempted suicide at some stage in their life in our Australian survey of 12,000 subjects. So there is clearly a crossover. However, self-injury is a very different kettle of fish to a straight-out overdose, and the vast majority of people get very angry if you ask them whether they were suicidal or whether they were attempting suicide while they were cutting or burning or whatever it was.

I suppose I have a history with this in that when I was very first a casualty officer in 1967 I was forced, as a 23-year-old, to sew up a man without anaesthetic. A nurse and I argued very strongly that we did not want to do that, we did not think it was right, but we were told that we would do what we had to do. We set about sewing this man up and, with each needle that went in, he would go, ‘Oh! Oh! Oh, Doc! Do it again, Doc!’ Unfortunately, at 23 I do not think I had the wit to ask him what he was experiencing. I did not have the wit to ask him about his past experience at that stage. I was not trained in psychiatry. I did not have the fascination that I now have for psychiatry. But I look back on that incident as absolutely appalling; I am ashamed.

Senator BOYCE—Were you asked to sew him up without anaesthetic as a punishment—

Prof. Martin—As a punishment.

Senator BOYCE—But in fact he rather enjoyed it?

Prof. Martin—That will stop him coming back again, but the man took it as part of his self-flagellation; whatever it was. We have run a series of seminars around Queensland where we have had 180 to 200 people turn up, and I often tell that story.

Senator BOYCE—Some of whom would be self-harmers; they are all identifying as self-harmers.

Prof. Martin—They have a specific interest in self-harm. They might be school principals or nurses. There is usually a small group of self-injurers who attend. What really fired me up about three years ago was that several people over a year sidled up to me and said, ‘That happened to me.’ I would say ‘What?’ ‘I was sown up without anaesthetic.’ I would say, ‘Are you serious? How long ago was that?’ ‘About a year ago.’ ‘Six months ago;’ whenever.

Senator BOYCE—So you are saying it is happening now.

Prof. Martin—That is exactly what I am saying.

CHAIR—We got an email about it.

Prof. Martin—The problem is that it is hidden and it suggests that some of our health care professionals are less than humane. We are trying to document that and, as you can imagine, a lot of the people who self-injure are not very comfortable about writing down their experiences. We did a survey of about 80 young people, videotaping them, and we are currently transcribing the videotape to allow us to pinpoint places. It is not just hospitals; it is often GPs in the community and others.

Senator BOYCE—Who would be others? I am just trying to think who else you would be getting to sew you up.

Prof. Martin—I was thinking of people in local hospitals: nurses, doctors.

Senator BOYCE—Community health centres; that sort of thing.

Prof. Martin—Yes. It is not necessarily our major hospitals, and at this stage we do not have written evidence to suggest that it is. I was certainly appalled. When you look at the relationship between self-injury and suicide, it suggested to us that there was a need for us to know exactly what was going on in Australia.

Senator FURNER—What age are these people who are presenting themselves to clinics to be sown up without anaesthetic?

Prof. Martin—Seventeen to 20, 22.

Senator FURNER—That is the average age.

Senator BOYCE—But you also mentioned in your evidence that you were surprised at the number of over-55-year-olds who—

Prof. Martin—That comes out of our national survey; it is not necessarily coming out of the seminar series or even out of our video examination or assessment of people. We were really surprised that there were people in their 50s still self-harming as a strategy to control anxiety or to relieve pain elsewhere—emotional pain.

Senator FURNER—Have they been self-harming for most of their lives?

Prof. Martin—Many of those people in later life had—although there were some in their 40s who began in their 40s.

Senator BOYCE—But it is generally an issue for younger people.

Prof. Martin—It peaked between 18 and 35 for both the lifetime rate and for the last-month rate. Can I just plug those? We were appalled to find that eight per cent of the Australian population at some time claimed to have self-harmed.

Senator BOYCE—You have got a figure here of 200,000 but that was just in the previous month. So you are saying 800,000 Australians—

Prof. Martin—No. Eight per cent of our sample claimed to have injured in their lifetime. If you extrapolate that—I think the figure is 1.1 per cent in the last month—to the whole of the Australian population you get somewhere close to 200,000 people self-harming in some kind of way in the previous month.

Senator BOYCE—Would that be the population? Are we saying that you would self-harm once a month at least?

Prof. Martin—Yes, is the answer.

CHAIR—Can I note that we had some evidence this morning that suggests that the same issue that you were talking of not having anaesthetic happened not so long ago. It sounds like it is still happening.

Senator BOYCE—We were a little surprised by that email.

Prof. Martin—I think it is part of the process of stigmatising people who self-harm. To be fair to professionals, I think it is very hard to be empathetic. The process of being empathetic is to put yourself in somebody else’s shoes. If that person has cut or burned themselves, for you to put yourself into their shoes to say, ‘I wonder what that is like. I wonder what they experienced,’ makes you shudder. I suspect that internally what our health professionals do is to kind of reject that thought.

Senator BOYCE—Wouldn’t that apply also to suicide attempts?

Prof. Martin—Yes, but cutting and burning is a very painful process, and I think it is the pain that makes professionals very uncomfortable.

CHAIR—Was there an approach in the past where it was considered as part of the treatment to get people to confront their self-harm by amongst some professionals by not treating with anaesthetic? It seems like it is quite a widespread shock treatment or practice, and it has been occurring over some time. I am just wondering: was that considered part of practice or what some time ago?

Prof. Martin—I think it is part of this stigmatising; rejecting; you’re wasting our time; why have you done this; why come here; why make me sew you up—all of those kinds of issues. I work very closely with quite a large number of self-injuring young people. They report that, on the whole, professionals get very angry with them because it is self-induced. The problem is that we are then making the process worse.

CHAIR—You could say that of a whole lot of things that our physicians treat: alcohol abuse; drug abuse. We heard evidence this morning where we have made some significant progress in those two areas. I am wondering why? Is it because this one is so obvious?

Prof. Martin—The nearest I can get is this issue of the struggle with empathy. I think professionals find it very hard to deal with that. Some of the people I talk with say that when they go into an emergency department they can see some nurses almost running away so that they do not get the case as they are so uncomfortable with the whole process. Yet this is a group that really does need empathy. My colleague, Keith Horton in Oxford, who has one of the largest long-term series of these, suggests that in five years five per cent of those self-injurers will have suicided. It is obviously a serious problem and we cannot treat it lightly. Of course, in schools and places like that where sometimes quite large numbers can occur and where copycatting can occur, it is an incredible problem.

Senator FURNER—We have heard today in respect to associated data on suicides. Is there an estimated result of figures in self-harming?

Prof. Martin—Very much so because of the nature of it. Many people who self-injure are quite ashamed of what they have done. They do not want people to know. They will, for instance, cut themselves in the shower so that they can actually cover up and clean up before any relatives or anybody else sees that they have self-harmed. They go to extreme lengths to cover it up.

Senator BOYCE—And cut themselves where it will be covered by clothes.

Prof. Martin—And cut themselves up. You will see a young woman, for instance, at school in the height of summer when everybody else is wearing a short-sleeve blouse, turn up with her sleeves down to cover it up. One of the things that is thrown at these people is that they are attention seeking. The young people laugh about this. They say: ‘How can it be attention seeking if I have tried to hide it? I do not want anybody to know that I have to do this to remain somewhere close to sane.’

Senator FURNER—Are we seeing increases in self-harming?

Prof. Martin—It certainly looks like it. Last year we completed a survey on university students, and 40 per cent of first-year psychology students at an eminent university in this town claimed that they had at some stage cut or burned themselves more than once. Twelve per cent claimed that they were still doing it in a regular way. That is fairly amazing. There are school surveys. One of my colleagues did a survey on the Gold Coast which suggested a figure somewhere around nine to 11 per cent, depending on how you defined it. My own studies in Adelaide some years ago suggested 14 per cent, although you have to take into account that a large part of that was once or twice. If you looked at three or more times you were down to about 2.5 per cent. It is a common phenomenon. It seems to be a sporadic but growing phenomenon. I would argue that once these young people have got into the pathway of dealing with their emotions in this way then they are at great danger.

Senator FURNER—As a psychiatrist, what is the treatment for it.

Prof. Martin—Oh dear!

Senator BOYCE—Before you answer, do these people generally have a diagnosed mental health problem?

Prof. Martin—We ran a therapeutic program—a randomised, controlled trial—about three years ago and something like 60 per cent of the young people were undiagnosable; they did not have a diagnosis. A common misperception amongst the psychiatry fraternity is that these are all borderline personalities or borderline personalities in the making. I do not think that is true. I thin these are traumatised young people who are trying to deal with a problem and have, sometimes by accident, found what from their perspective is a good way to do it, even if it is uncomfortable for the rest of it to look at. Therapy is problematic. Our randomised, controlled trial disproved some English work on the same kind of population that had shown that cognitive behavioural therapy with young people was helpful. Our study showed that, in fact, it was not. We were unable to show any benefit in terms of changes in depression, changes in self-harming behaviour or changes in overdose experience.

There is a better developed form of CBT called DBT—dialectical behaviour therapy—developed by Marsha Linehan. This was developed on adults. It seems to be more coherent. It includes looking at the system rather than just looking at the individual. It now includes some mindfulness as well, and the results are really quite good. Unfortunately, when you translate it to young people it is problematic because you have to commit to a year’s therapy and adolescents struggle with anything past about 10 weeks. So it is problematic to do that, but there are groups around this country using DBT with young people who self-harm. The other thing about it is that those therapies are what I would call left-brain therapies: they are logical and organised. A lot of these young people are disorganised and really touchy-feely, right brained people. Last year we trialled a voice and movement therapy, which—on very small numbers certainly not at the level of statistical significance—showed some stunning results. We will be repeating that and trying to do a randomised, controlled trial to take that work further.

There are a number of other experiential therapies that have been tried. The problem that bedevils this whole area—and I mean that in the sense of suicide—is that really the research is very poor and the evaluation of programs, generally speaking, is very poor. We have struggled with this since the adolescent strategy, the youth strategy. We could not get more than about 20 per cent of the programs to produce decent evaluations. It is very hard to do. It is very hard to get people to do the valuations. Of course they do not like writing papers—we academics do—so then you never hear about the work that they have done and we are then in danger of repeating all of the mistakes that they made.

Take that through to Aboriginal culture where they have got wonderful programs like Drop the Rock and things like that that are quite stunning: who is evaluating it to the point where the rest of the community could say that it is respectable and acceptable? Sorry, it is a personal passion of mine to get people to evaluate things. I am not talking about it at a really heavy level, but just to make sense of what they have done with their program.

Senator MOORE—Isn’t it built into funding now that you have got to evaluate?

Prof. Martin—Are you hoping to wriggle out of that?

Senator MOORE—It is a directly leading question, Professor. How do people wriggle out of that?

Prof. Martin—They wriggle out of it by not doing it, and then suddenly remembering two-thirds of the way through the program that they have got to do an evaluation, which then has to be retrospective rather than prospective. This is a field where people move on quite a lot, so they move on to other programs, or the evaluator moves on, or they have got a philosophical view because it is a youth program and they are not having any of their young people researched. There are lots of ways of wriggling out of it.

Senator ADAMS—I am interested in your comments about the New Zealand Suicide Prevention Strategy, and especially reducing Maori suicide. Was that just Maori and Islander program, or separate?

Prof. Martin—It was a combined Maoris and Islanders, but the program seemed to be probably more Maori driven. It included Islanders but it was more Maori driven. But the changes were in both groups.

Senator ADAMS—And it was funded specifically as a Maori—

Prof. Martin—No, it was funded as a national New Zealand strategy.

Senator ADAMS—I thought that was the reason you were looking at the National Aboriginal Youth Suicide Prevention Strategy—

Prof. Martin—They divided it into halves. There was an overall national strategy and one half of it was specifically for Maori. They have got a strong lobby, haven’t they, with 15 per cent of the population being Maori? They have got a much stronger lobby than 2½ to three per cent in this country.

Senator ADAMS—Here in Australia there are probably, while not quite full blood, much stronger blood than New Zealand. I came from New Zealand originally so I can assure you that the Maoris I see and speak to when I go back look a bit different. The Maori features are not nearly as strong, perhaps, as they were when I was going to school with a number of Maoris. So that is just a difference and, given that the Maoris and the English have probably been together and married and had their children and then there are their children, that is understandable. Whereas, the Aboriginals perhaps have not integrated quite so quickly and it will probably take a lot longer.

Prof. Martin—I think that is interesting. I was talking with my Aboriginal colleague, Norm Sheehan, today around another matter and he was joking that Aboriginal people in this country are actively seeking partners outside Aboriginal culture, and actively seeking to increase the birthrate for Aboriginal people. They are actually extremely worried that people have suggested at a high level that we could have a 35 million population at some stage in the future, because then their little bite of it would be much smaller. So there are some very interesting politics developing there.

Senator ADAMS—I do not know whether that is where the Maoris went. I think it was just one of those things, but the Maori population is certainly not increasing. We did have someone mention earlier the Islanders being a little bit like the Torres Strait Islanders and the Aboriginals and the comparison was given of the New Zealand Maori and the Pacific Islanders. That is why I was really asking.

Prof. Martin—If you look at Canada as another example, you can say when you develop a specific program for native Canadians, you can bring the suicide rate down quite successfully. I think Michael Chandler’s work with Chris Lalonde has shown that. If it is a specific, directed program with a very heavy input from the native Canadians, they can make a difference. And there is some work from the States that is showing the same in Red Indian communities. I think a specific strategy would be a very sensible thing to do—but hard.

Senator ADAMS—Yes, I am sure it would be.

CHAIR—As per usual we have run out of time. We do that consistently. Thank you very much for both your submission and your time today. It is very much appreciated.

Prof. Martin—My pleasure.

[4.06 pm]

GROVES, Dr Aaron Robert, Executive Director, Mental Health Directorate, Queensland Health

CHAIR—Welcome. Is there anything you would like to add to the capacity in which you appear today?

Dr Groves—I am also here as the Chair of the Queensland government's Suicide Prevention Strategy steering committee. I note that you have heard some evidence around several of the programs, which we fund through Queensland governance. I also have that capacity. I also have another role in that I chair the national Mental Health Standing Committee, which is one of the AHMAC committees in relation to mental health, and so I can talk about some of the questions that might relate to the Fourth National Mental Health Plan. In addition to that, we have recently streamlined the two major Queensland government processes for mental health reform. They were our COAG group and our interdepartmental committee, and we have now formed what is called the Queensland Mental Health Reform Committee, and that looks at mental health reform across Queensland. For my sins, I happen to chair that as well, so I am more than happy to answer any questions in relation to that governance.

CHAIR—You may just want to let us know when you are flipping hats.

Dr Groves—I will try.

CHAIR—I understand you have been given information on parliamentary privilege and the protection of witnesses and evidence. As a departmental officer, you will not be asked to give opinions on matters of policy, although this does not preclude us from asking you questions for explanations of policies or factual questions about when and how policies were adopted.

Dr Groves—Yes.

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

Dr Groves—Thank you very much. I would like to start by acknowledging the traditional landowners of the land that we are meeting on today, the Turrbal and Yuggera people, but also other traditional landowners right across Queensland. Living in a country with the longest history of the existence of people, I am very aware of one of my colleagues, Professor Helen Milroy, from Western Australia, who makes the comment that Australia's first people are in fact incredibly resilient, and in fact many of the issues that relate to them are things that have really cropped up in the last five or six decades or so. It is something I might come back and address later on during the submission to the hearing.

The other thing I wanted to do was start by talking a little about some of the aspects of data. Certainly from Queensland's perspective we know that probably as many as half a million of the 4.2 million people in Queensland will at some time think about suicide, will self-harm in some way or will have some sort of plan to suicide, but only a very small number of those people will suicide. So we know that probably 13,000 people in any one year will make an attempt to either self-harm or suicide, but in Queensland about 500 people sadly lose their lives to suicide. What I am trying to capture is that in fact the translation from people thinking about suicide or self-harming to actually suiciding is in fact a rare event, and the capacity of professionals to predict that suicide is a very variable. There are a lot of things we know are making it more likely that somebody will suicide, but ultimately it is very difficult to predict.

The consequence of that is that we need to have an approach that deals not only with those people who are highly at risk of suiciding, but also a system that supports all people who have various degrees of emotional distress, desires or capacities to self-harm, right through to those people we know are at highest risk. I am very prepared to talk about the Queensland Health clinical system because that is an aspect that supports a very small number of people who might be suicidal. But I think we need to put forward that our approach to dealing with suicide is entirely across government and that it needs to be streamlined with our approach to dealing with mental illness, mental disorders and how to improve mental health. Within that we have an approach that is trying to change from the paradigm of 10 years ago, where there was an approach towards trying to get more clinical services to people. I am aware of the evidence that Professor Martin has already given about the usefulness and sometimes lack of that for people who might be self-harming or feeling suicidal, right the way through to those generic counselling support services that clearly should be given to a number of people who do not need clinical services. One of the important aspects of the way in which we approach dealing with suicide is to try to target the right type of people with the right type of resources for the particular problems that occur.

You can imagine that is an immense task in a state the size of Queensland with the population that we have. So the way in which we have gone about that in the past couple of years has been to try to get much better coordination for all sorts of services, no matter where the particular funding of those services might be. I just wanted to comment on one particular aspect around that. I understand in some of the evidence that was given earlier this morning people talked about service integration. Service integration has been a very important hallmark of the way in which Queensland government has gone about trying to address the COAG plan for mental health, and I notice that Professor Martin commented about following COAG, there was a much better approach towards coordination.

The way in which we have approach it in Queensland has been a little bit different from some of the other states. In fact, at a previous Senate committee I talked a little bit about that, and I am happy to give an update about how we have been going. The first aspect was we recognised that to try to get those providers who come from the non-government sector, from housing, from support services, from clinical services and primary care to those people who need it to help them not fall through the gaps is not something that can just occur by asking people to add that to their usual job. So the Queensland government put $4.7 million into appointing service integration coordinators whose role is to start integrating the approaches that non-government sector providers, housing providers, disability support providers and the clinical services provide for people who are living with severe mental illness, but also who might be at risk of a whole host of other problems. That is a strategy which we believe has been very successful so far in making sure that the group of people who have been identified for service integration have been able access to that full range of services that they need.

We also recognise that it does not just stop there with those groups of people with a range of complex behaviours or complex problems that might need multiple agencies. We recognise that that same degree of coordination needs to occur with primary care. One of the problems we have heard time and again in Queensland during the past five years has been that it is difficult for the primary care sector to get the support of the specialist system, and likewise the specialist system often finds it very difficult to access primary care and get the same degree of response that they might imagine or wish to have. That is particularly so the more you get outside of the metropolitan parts of Queensland. One of the things we have done is developed what we call the Queensland Framework for Primary Mental Health Care, sometimes called the partners in mind framework, and that framework is now being rolled out with funding to divisions of general practice and then also to our local mental health services to try to get a much better and closer working relationship between primary care providers and the specialist assistance. So we recognise that without putting specific effort in, we were not going to get results.

In addition to that, we have taken the same type of approach with transcultural mental health aspects, with coordinators and with dual diagnosis. I think you would be aware that, again, throughout Australia there has been concern about the links between specialist mental health services and specialist drug and alcohol treatment providers. So, again, we have been putting specific effort into trying to link up those two sectors because they are particularly important for those people who are at risk of suicide.

They are four particular strategies into which the Queensland government has put a sizeable investment and it is using those as the main vehicle for trying to make sure that people do not fall through the gaps and that they get access to the right services whenever they can and where they are available. I am recognising the fact that we come from what has traditionally in Queensland been a lower investment in mental health than some other states. However, we have made a sizeable investment during the last four years. The investment by the Queensland government in mental health since September 2006 has been $1 billion. That is the investment. Obviously all of that is not turned into funding, because it is a five-year plan, but that is the government’s investment in mental health over that period of time.

We have a 10-year plan that was launched by the Queensland government in 2008, despite the fact that it is called a 2007 to 2017 plan, but we have these issues! We are now two-and-a-bit years into the implementation of that plan. Clearly, an important aspect of how the Queensland government plans to take forward mental health prevention, early intervention, suicide prevention and mental health reform is outlined in that plan. I am more than happy to talk about how that is progressing and how that ties together all the efforts that we plan to put together. I will pause there and leave you to ask questions.

Senator MOORE—Dr Groves, it is good to see that you are here and that the submission has been provided to the committee. That is a good start. Regarding the coordinator positions that you mentioned and which we have heard about before, it seems that that kind of role is being talked about across the nation in this area. Regarding the positions in Queensland—and I do not know them—are they in every health area?

Dr Groves—We originally created 20 positions because we had 20 health service districts; we now have 15. We have put them where the local districts told us it was best to place them. So, if we take the far north of our state, there are 1½ positions in Cairns because they do more than just

Cairns. In inner Brisbane, for example, there are more than you would identify for a district. For example, the metropolitan south health service district has two because metropolitan health is a large district and it has a big population to cover. So it does not actually work on the basis of each district having one; it is more on the need, the requirement and the work complexity.

Senator MOORE—Does each district have at least one?

Dr Groves—Yes, even the central west, where there is a low population, one is allocated for it.

Senator BOYCE—The position is filled?

Dr Groves—I understand it is—yes.

Senator MOORE—In terms of the discussion, there were two things mentioned this morning in evidence given by a group of people who came to see us and talked about the need for that coordination. They also mentioned a couple of places where they thought there had been an effective coordination of services on the ground. That looked at mainly non-government facilities, but some were government facilities as well. They named a couple of areas where they thought it was working really well, which was a positive. Regarding the Far North Queensland area, we heard evidence about the post-cyclone focus. Certainly, from my observation, there was an enormous amount of effort put into the far north post the cyclone, which I think has benefited the whole region subsequently. There is a greater awareness and focus up there. They talked about a good way of getting all the services on the ground together. The point that you raised was that, if the coordinating body coordinates the services, how do clients get into that system? You have the coordination, so someone knows what is there. How does the client get into the system and then get the services to say what would best fit them?

Dr Groves—That is an important aspect. What we try and do is define that this is an approach for a specific small group of people: people with the severest and most complex forms of mental illness who are most likely to fall through the gaps. They are some eligibility criteria, if you like, for coming into this particular approach. Eleven departments of the Queensland government have committed to providing services preferentially for those people. The service integration coordinators' role is to help link up those services so that, if somebody is referred into that process, all of those services agree to prioritise that particular person for whatever services are required—and obviously they will change over time.

One of the important aspects of what the service integration coordinators do is not just identifying that people are making sure they are linked up to their services; it is to do with cultural work between various non-government providers and different service sectors in starting to understand and take on mental health as a responsibility. So it is across education, training, police, ambulance, corrections, health, disability support and Aboriginal and Torres Strait Islander; you can go right through the list of all the people who we might need to link up. Again, as you will see in our submission around suicide prevention, our approach in the last few years has been to get all of those government departments committing to what aspect they contribute to needing to assist somebody with a mental health problem.

Senator MOORE—So what their responsibility is?

Dr Groves—That is right.

Senator MOORE—Then how are they assessed? I will not go with a case like housing, because that is too easy. You have heard the evidence about emergency departments.

Dr Groves—Yes. Emergency departments are a difficulty, and very few of these people who are in the care coordination model are necessarily going to be going to emergency departments. That is probably a bad example to think of. Perhaps a better one to look at is that if somebody, for example, has had schizophrenia for quite some time—

Senator MOORE—Already diagnosed and in the system?

Dr Groves—Already diagnosed, or even if they are not diagnosed but the GP might think that is what the issue is. There is a lot of complexity, because they might have been not accessing clinical services for some time. That referral would come in to the service integration coordinator. They would start to look at what sorts of services the person might need to access. It does not even mean that they need to access Queensland public mental health services, because if the GP is quite happy with the service plan and is happy looking after this person, who might have a diagnosis of schizophrenia but is having difficulty getting disability support, housing support and vocational support, then we would link up with those agencies locally in the town to ensure that the person gets prioritised for those services.

Senator MOORE—One of the issues, though, seems to be that you have to have reached a certain degree of disadvantage before you can access the system.

Dr Groves—That is right.

Senator MOORE—There is an argument that anyone who is struggling with mental health—and, in particular for this committee, anyone who is struggling with issues around suicide—needs this automatically.

Dr Groves—Indeed.

Senator MOORE—I do not think that in the current model they fit automatically.

Dr Groves—No. In fact, part of that may be a little bit of an under-plan for what comes next, because clearly part of what we wished to do was to target those people who had the greatest degree of complexity but to start to get the service systems talking with one another—

Senator MOORE—Yes, even embedded.

Dr Groves—and developing those relationships. It is pretty hard to do that when somebody’s needs are much lower than those that are identified as having an enormous amount of complexity. I think it is also fair to say that there has been a change across governments in all states and territories and even in the Commonwealth in the understanding that mental health is not just the business of health. The Queensland government has needed to have that approach of making sure that corrections, police, ambulance and emergency services departments recognise that they have a role in providing services for people with mental illness.

Senator MOORE—The two other issues that I am really interested in—I will put them on the table with the others—are: (1) the data, because of the stuff that is in the submission about the particular processes that Queensland Health have done; and (2) the issue we have heard about emergency departments and their training and awareness.

CHAIR—Let us explore this issue a bit more, because I know I have a couple of questions here. Maybe, Senator Boyce, you and Senator Adams can follow up on this particular issue, and then we will move on to the data issue. It is better than chopping and changing.

Senator BOYCE—You would have heard Professor Martin’s evidence earlier about people who have self-harmed being sewn up without anaesthetic. We received an email—it was tabled this morning—from a woman claiming that that was done to her. What has been said to the Department of Health about this topic?

Dr Groves—The first time that this was mentioned to me was when Professor Martin met with the Director-General of Queensland Health. I was actually in the room. At that point, I asked Professor Martin, if he has examples that clearly relate to the public mental health system or even the public health system, to provide those to me so that I can follow them up. I think he made the point in the evidence that he gave that they are currently going through a process of looking at trying to clarify that, because some of these people were saying this was their GP and some of them were probably identifying other healthcare professionals. From our perspective, if it can be identified that this has happened in the public system we would absolutely straightaway deal with that issue.

The Director-General of Queensland Health spoke to this issue when it was raised with him by the media. I think the important take-home message here is that we know that one of those issues that are indicated in the transition from people who self-harm or are planning to suicide to people who then ultimately suicide is the issue of hopelessness. Hopelessness is in fact one of those quite good indicators that somebody might go on and suicide.

There is nothing more despondent, distressing and demeaning to somebody’s self-esteem than to do this. All it would do is lead to a higher likelihood that somebody is going to suicide. Even in that group of people who might be self-harming for reasons to do with dissociation and dealing with internal distress, there is still this element of hopelessness that starts to be introduced.

Senator BOYCE—What would the department of health see as its responsibility if this were happening in areas other than the public hospitals that you have direct responsibility for?

Dr Groves—We also have a Health Quality and Complaints Commission in Queensland. Its coverage is for all of the health system, including outside the public health system. It is the sort of issue, from my perspective, that would lead to a complaint being raised directly with the Health Quality and Complaints Commission. They have the powers to investigate that and make recommendations.

Senator BOYCE—But they would have to be made by the individual who was affected?

Dr Groves—They could be made by the department.

Senator BOYCE—So the department could complain to the commission about the activity of hospitals or hospital departments or individual health professionals?

Dr Groves—That is right. If they believed that there was clear evidence that the matter should be referred to the Health Quality and Complaints Commission, they could refer that.

CHAIR—White Wreath received this email this morning and they gave it to us. It is a recent one. We took it confidentially because I was worried that it might identify someone. It in fact does not. We will just double-check that it is a Queensland example—that is what I understood it was—but we can hand that on to you, because it does not identify the person, and ask you to follow that up.

Dr Groves—I would be more than happy to do that.

CHAIR—Thank you.

Senator BOYCE—It seems to very clearly set out that it is happening, from the evidence we have had. You wanted to talk a bit more about emergency departments.

CHAIR—We might talk about emergency departments a bit later. At this stage I want to follow up on the issues that we have just been talking about. I have some questions about service integration, specifically service plans. I want to follow on from where Senator Moore was asking questions. With the services that we were talking about, the integrated service coordinator deals with those that are at the highest risk. Do they all have service support plans?

Dr Groves—Yes, they do. They have quite comprehensive care plans. Those have each of the elements of the departments that might be involved with the particular person, and they would be modified depending on what the particular person’s needs are. The issue here is more about complexity than risk. Risk obviously comes into it, but it is more risk of not getting services. It is more about complexity of the person’s problems.

CHAIR—A lot of the evidence that we have received, both today and yesterday, is around prevention. The evidence we received yesterday was that, around Australia, 65,000 people attempt suicide a year. I accept your point that only a proportion of those people then go on to another attempt or a successful attempt. However, that is still too many. They may not be as complex cases, but they still need support. It seems to me that those are the people who are that falling between the cracks at the moment.

Dr Groves—If we just look at that group of people who have made some sort of suicidal attempt, and I think this is where Professor Martin also quite nicely articulated, there are still two groups here. There are those people who are self-harming, and they would laugh at the idea that that was actually about them suiciding, and then a group of people who might have been doing that as part of a legitimate suicide plan but for whatever reason that was unsuccessful and they did not suicide. The approach here is to try and link up who might ever be involved in their care. Again I think that some of the evidence that has probably come to the committee is that some of those people need much lower levels of support; they certainly do not need clinical support. Some people need an enormous amount of clinical support and some people may even need hospitalisation because they have diagnosable mental illnesses that need to be treated. It is a little bit difficult to talk about exactly how that is split up in terms of numbers and percentages because we do not really easily have it. One of the things that I would like to mention, though, is that the largest mental health clinical service provider in the country is in fact primary care, general practice. If you look at who provides the most care, it is general practice. General practice has a very key role here in being able to sort through what are the problems that people have, those that can have certain degrees of counselling that does not require clinical input, that that needs clinical input and that that needs specialist care. That is one of the fundamentals we have tried to build our mental health system on, but it does not work terribly well.

CHAIR—Various states seem to have a different degree of follow-up after release from acute care in hospitals. There is varying evidence about how many people actually get that support. There is quite a bit of evidence to suggest too that there is a high proportion of people released that do not get follow-up care that then make a successful attempt. The other evidence we have received is that GPs are not necessarily the people that people want to go and see. In Queensland when people come out of hospital, for example, are they automatically referred back to their GP—if they have a GP; not everybody has a GP.

Dr Groves—We have got some guidelines for the management of people who are at risk of suicide or have suicidal behaviour. It might be worth while me sending them to you because they give you an aspect of what we expect a person who makes an assessment of somebody who is suicidal to do. It is really trying to end up with a care plan that makes sense for whatever the assessment of individual person is. My expectation certainly is that if a person has a GP and the GP is identified and they believe the GP should be involved that we are communicating with the GP. One of the successful partnerships we are about to work on with DOHA—and there are some—is that they are putting funding into two parts of Queensland where they will have a dedicated worker who will work with general practice and will have a dedicated worker who will be in the emergency department to try and ensure the links and that people do not fall between the cracks. That is a very specific general practice to emergency department—

CHAIR—So each division of general practice—

Dr Groves—There are two that we are piloting. We will have two divisions, and they do have pretty good coverage in Queensland of all the general practices, most of the divisions. Then somebody who will be identified within Queensland Health will be working out of the emergency departments will try and link up those people who have been seen in the previous 24 hours and making sure that the GP knows about it and gets the discharge summaries, and if there are any concerns that that goes on.

Senator MOORE—Have those regions been identified?

Dr Groves—Yes, they have. They have not been announced yet. I wish I could let you know.

CHAIR—It was worth a try.

Dr Groves—The other issue is that where we probably do not do so well is how are we would link up those people who might have been assessed in emergency departments and their care plan does not involve their GP. It might include some other counselling type of service, some other provider, sometimes someone with a clinical background.

CHAIR—This is presuming they have got a care plan.

Dr Groves—That is right. So you would expect that if somebody has had the adequate assessment that we believe they need to have that a care plan will be made. So unless the particular issue that brought them to the emergency department was so trivial and had blown over that they do not need a care plan, and that is something that does occur from time to time, then we would expect a care plan that is comprehensive about trying to ensure the person is not coming back to the emergency department—

CHAIR—Before they leave the hospital.

Dr Groves—That is right. It is before they leave the emergency department.

Senator ADAMS—While we are on that, can I ask this. All I want to know is if you have a separate triage for anybody in that situation or for mental health issues.

Dr Groves—Is that about the triage scale?

Senator ADAMS—After coming straight in, are they triaged off to see a psychologist or a psychiatrist? Is there an area in the hospital where they are not left sitting exposed for, as we have heard, seven to eight hours just for the general accident and emergency people?

Dr Groves—We have different models in different hospitals. Perhaps I can give you some examples. The Royal Brisbane Hospital, for example, has its own psychiatric emergency centre, so people would be quickly streamlined to that particular area. That is manned by mental health staff. That is the only one that we have in the state that is a dedicated psychiatric emergency centre within the floor area of the emergency department. Other large hospitals such as the Logan and Gold Coast hospitals, which have very large volumes of people presenting to those emergency departments, do not have a dedicated emergency centre but they have dedicated staff that would work within the emergency department.

Senator MOORE—How about Ipswich?

Dr Groves—I am unsure. I am sure they do have some staff but I am not sure of the degree of coverage. They certainly would not have the same degree of coverage as, for example, Gold Coast and Logan have.

Senator MOORE—Senator Adams, I think the two examples we had this morning on *Hansard* were Ipswich and Gold Coast.

Senator ADAMS—Gold Coast was definitely one. I was interested because I know how WA's is set up. I was just wondering how the Queensland situation is.

Dr Groves—If you went to some of our smaller hospitals, they really have little more than general practice and general nursing staff in them. It is really quite different in that regard from some parts of Western Australia, for example.

CHAIR—Can we go back and finish this care plan issue, if that is okay, because I do have a few more questions. I refer to the trial that you were talking about. Is that a specific Queensland trial or is that being trialled in each of the states?

Dr Groves—It is all part of one of the two flagships of COAG. One of them was called Care Coordination. We have chosen to do it in Queensland differently from the other states. The other states have had little trials that they have had in certain parts of their state or in certain sectors within mental health. Ours is to cover the whole state and to cover all of mental health. That is partly why there was a specific investment in it. Also, we do not see it as a trial; we see it as an ongoing reform to our mental health system, so these are recurrent resources. With time we expect their roles will change. But we do not see it all as being something that we are going to pilot and then stop. We actually believe it is a fundamental way of doing mental health service delivery differently.

CHAIR—So putting somebody in the division and having someone in the ED—

Dr Groves—I am sorry—

CHAIR—That is the trial that I was talking about; sorry.

Dr Groves—Sorry and I apologise. That is a trial that is hopefully something that if we can get resources from both levels of government would be expanded with time.

CHAIR—Is it just Queensland though?

Dr Groves—I do not know. This was something where the Commonwealth approached me to say this was something that they wished to do and where could I advise them to do it. My approach to them was to say, ‘If you’re planning to do that, we’ll match something up and do it in the same area so that we collaborate together on this’. I am aware that something similar occurred in the Osborne Park Division of General Practice and the Sir Charles Gairdner Hospital in Western Australia back in about 2003. So I am aware that it has been done elsewhere but I do not know across the country—

CHAIR—We will check on our travels.

Senator MOORE—Is it still being done at Osborne Park and at Sir Charles Gairdner?

Dr Groves—I am unable to comment on that.

CHAIR—We will find out.

Senator MOORE—I think it might be nice to trace that to see whether it is still happening.

CHAIR—We will find out. I want to go back to the care plan, and I know that we are going to need to move on to another issue. If somebody is coming out of an ED and it has been judged to be a major episode they will come out with a care plan; is that so?

Dr Groves—Yes. If the person was judged to have had high risk they really should only be leaving the hospital if we know that the environment they are going to fully supports them, that the family or somebody else is going to be able to ensure their safety and that the other clinical providers that might be involved in their care can do that. It would not be right to do otherwise. So you have got to try and line up the care plan with the risk.

Senator BOYCE—Anecdotally, we have heard lots and lots of stories about people leaving emergency departments or leaving hospitals without a functional care plan.

Dr Groves—I understand that. I often hear that and then I look at files and see there is a care plan, so there is a care plan document. But how they actually translated it to everybody might have been the difficulty. Sometimes there is also not the adequacy of care plan there. I think it is fair to say that in an industry that is as large as what an emergency department is it is very difficult to get everybody reaching the standard. We would expect that we need to keep beavering away at that.

Senator BOYCE—A care plan that says go home and make six phone calls—or whatever it says—is scarcely worth the paper it is written on.

Dr Groves—I totally agree with you. Part of the issue here is us trying to outline to services the degree to which they should be engaging family and other people in agreeing to the service plan and also what role there might be and also for the other people who might be the providers of care for somebody. My strong view is that those things need to be aligned.

CHAIR—We will move on to data.

Senator MOORE—Doctor Groves, you know how important the aspect of data has been in the submissions to this inquiry. In your submission, you go into the issues around the Queensland suicide register. Naturally, the Queensland one is peculiar to Queensland but are there suicide registers in all of the other states as well?

Dr Groves—Some states have suicide registers and some do not.

Senator MOORE—Quite focused work seems to have been put into establishing and maintaining the Queensland register. You also say that limitations with national suicide surveillance mean it is not possible with any certainty to compare the situation in Queensland with those of other jurisdictions.

Dr Groves—We are fortunate that the Queensland government, through Queensland Health, provides funds in the order of $215,000 to the Queensland suicide register each year and has been doing so since 1990. Certainly since 1994 we have had a very comprehensive way in which we collect data. It is very useful for informing us around decision-making and policies in relation to that. We have known, and I think Professor Martin has already talked about this a little bit in his evidence, that in the early part of this decade there started to be a separation between the rates that were being reported through the ABS and the rates that were at least being known in some states. I think there are a couple of reasons for that. Professor Martin has talked about one of them: the number of people who perhaps have been miscategorised. There is also another issue that has been clearly known by the ABS for some time. They count the suicides that occur in a particular period—that is, the previous year or the year they are reporting on—and if cases are not closed off by coroners they do not get in. I understand, although I am not sure if it has been formally announced, that in a couple of weeks time in the next ABS release—

CHAIR—on 17 March—

Dr Groves—at 10.30 in the morning the next causes of death of data will come out with 2007 having been historically readjusted. Certainly the Queensland government has been aware for many years that the Queensland data is significantly higher than reported in the ABS. We can historically readjust because we look back, and that is how we report our suicide data to the public in Queensland through our bureau. Our views are still similar to what Professor Martin has said, that there has been a small reduction in suicide particularly in the last few years; however, it is certainly not as strong as what the national figures would say because the national figures are not correct.

Senator MOORE—I know the SPA have got their working group to try to look at data collection in this area but it continues to bug us that we cannot look at national statistics in data collections. Taking the working groups of COAG, I know there is another working stream within COAG that is looking at data collection. Has there been progress to try to ensure that at least at the state level, allowing for the ABS being the national collector, the kind of work that is done in the Queensland registry be replicated in all states so at least there can be the ability to look at national surveillance, because your submission clearly says you cannot given the current state.

Dr Groves—With the National Committee for Standardised Reporting on Suicide that you have spoken about I know that Coroner Barnes, who is the Queensland coroner, has been very active in ensuring that there is some consistency that occurs. Once we have that then we can start to compare what goes on. Having said that, the states of Australia are not all the same. We have issues that I think you have unpacked in terms of Indigenous suicide. I fully support the sorts of things that have been said. Indigenous suicide is very different from non-Indigenous suicide. Youth suicide is also very different from non-youth suicide. They are not all the same. There needs to be a different approach and if the demographics are different then the suicide rates are going to be different.

Senator MOORE—It seems that the work done by the child commissioner again is leading in that area but so far has not got the ability under our Constitution to demand that other states meet that. There will be no doubt another recommendation in this committee on this issue about data but it has almost become black comedy.

Dr Groves—Having said that, and I understand the black comedy, I think it is worth recognising that people within the national mental health agenda for several years have been saying, ‘We need to have this sorted out.’ The ABS has agreed and it is being sorted out.

Senator MOORE—There was a term used yesterday by one of the witnesses ‘waiting with’ something for the 17 March figures. It was almost excitement which indicates the need.

Dr Groves—I will not be waiting with bated breath or naked anticipation. We know what they have been and all this is doing is reaching a standard similar to what Queensland reports.

CHAIR—We heard yesterday the Victorian coroner is not reporting—

Senator BOYCE—Births, deaths or marriages.

Dr Groves—I did hear something along those lines at a meeting about a month ago.

CHAIR—We will be asking about that on Thursday.

Senator BOYCE—I wanted to go to the Indigenous people and communities and you began to cover the point I have asked about several times today which is the fact that we very rarely distinguish between Aboriginal and Torres Strait Islander. Is there anything you can tell me about Queensland Health's approach to suicide and Torres Strait Islanders that is distinctive to that group.

Dr Groves—Probably not a lot, Senator. It is fair to say that we have taken an approach of trying to have local community approaches to Indigenous communities or communities that have high numbers of Indigenous people on the basis of what is appropriate for their needs. I know you spent a little bit of time looking at the Yarrabah project. That was a partnership between government and mental health and the local community. To unpack that a bit the local council and the local community were involved but we have had a number of people who started in that community around that time that assisted in the development. An enormous amount of effort has gone into the Yarrabah partnership in that way. We have also perhaps not quite replicated but done a similar thing with Indigenous communities at Wujul Wujul and Hope Vale as well. One of the important lessons in this—and I think that one of the representatives from AIPA mentioned this—is that what was an almost unheard of circumstance 50 years ago is now widespread in some Indigenous communities but still not in others. It would be entirely inappropriate for us to do something in a community that does not have a problem with suicide because they do not want that. So we have made sure that we go to those communities where we know there is a problem and where we know we need to deal with things.

Perhaps I cannot talk so well about the Torres Strait as an example of things being different. What I can say is that each of the different parts of the Torres Strait—the east islands and the west islands and so on—would consider themselves to be different. There are also the issues of people from Saibai in Bamaga and so on. So we are trying to take an approach of working with the local community about how they wish to do that. I think that some of the social and emotional wellbeing centres that we have had up in the northern peninsular are the sorts of things that the Torres Strait wants to replicate.

One of the issues that we want to make very sure of, in doing that, is that those people who need more than just a social and emotional wellbeing response—that is, those who actually need some clinical services—get married up with the clinical services. You would recognise that it is very difficult, in fact, to recruit and get clinical services there. It gets back to the point that the AIPA made: unless we have a very good strategy for encouraging people who come from those communities to get into the health industry it is very difficult to recruit in.

We have an Indigenous workforce strategy for health in Queensland. I know that in the mental health sector we now have in the order of 90 Indigenous mental health workers. That is certainly a good start for us in terms of making sure that we have a number of Indigenous mental health workers throughout our sector. We still have a fair way to go and we clearly need to work in partnership with the Torres Strait community and the council as much as we need to work with other communities in Queensland.

Senator BOYCE—Just going back to the point you made about some communities having a high prevalence of suicide and others having none, is there anything distinguishing those communities from each other? Is there anything we can learn from comparing those communities?

Dr Groves—One of the things we have done as part of the Queensland government suicide prevention strategy, is to fund one of the partners to start to look at some of those issues. In our view the amount of proper evidence based research about that is pretty poor across the whole of the country. So that is one of the things we have funded under the strategy.

Senator BOYCE—For Queensland?

Dr Groves—For Queensland. That is the Queensland suicide prevention strategy. I think some of that has been picked up in our submission. One of the things we do know is that people we have had working in those communities for the last couple of decades have an enormous amount of anecdotal knowledge about what is different between the communities that have suicide as a problem and those that have less of a problem. Again a lot of this is to do with how Indigenous cultures work. Those communities that have started to fall apart because of the fabric of the community, clearly have much greater problems than those that have not. I am sure we can go through and characterise what those might be and I am sure they are well known to the committee. We have some very healthy Indigenous communities in Queensland and we have some that are travelling nowhere nearly so well. That seems to be the biggest predictor of whether those communities will have a problem with suicide—particularly youth suicide.

Senator BOYCE—Sometimes you are not sure whether these things are intuitive or counterintuitive.

Dr Groves—I am sure they would be no different from Balgo or any of those parts of the Kimberley.

CHAIR—I wanted to go back to the issue of Indigenous strategy—AIPA recommended the adoption of a separate strategy and Professor Martin touched on the issue as well. What are your comments on the need for a separate strategy?

Dr Groves—Again, I might take off the Queensland government hat for a short period of time and put on the national hat. The national mental health plan—the fourth plan—has two actions that relate to suicide and there has already been a group established by the Commonwealth to start to look at how we align state and Commonwealth suicide prevention strategies. There is also an action to really dust off the old national Aboriginal and Torres and Strait Islander social and emotional wellbeing plan and put it into practice.

CHAIR—That would be novel.

Dr Groves—Yes, most of the people who are familiar with the framework would actually say that it is a good framework, but the amount of activity that went underneath it was not that impressive. The standing committee has already tried to form a partnership with the National Indigenous Health Equality Council—I think that is the correct name of the group—to start to look at how we work on developing a new social and emotional wellbeing national framework. I believe that is where the discussions around: does a specific national Indigenous suicide strategy plan fit within that? My view is, yes, but I think that is something that the sector would need to agree to and decide. It is important to recognise that, whatever happens, what will be important is perhaps the point Professor Martin also made that we cannot take our eye off the specific investment in suicide prevention nor should we with Indigenous people's mental health, and clearly the two of them significantly overlap. One of the features of the endorsed national mental health policy is that it was the first health policy that I am aware of that specifically acknowledged the Indigenous heritage of our country in a formal way. I think the plans, therefore, have to line up with that and address the Closing the Gap issues as they specifically relate in mental health.

CHAIR—You took on notice to provide us with the Queensland guidelines. Thank you very much for both your submission and your coming here today. We particularly appreciate state governments coming and taking the time to participate in Senate inquiries because many state governments do not.

Dr Groves—Senator, can I clarify one thing? There may have been an administrative oversight. I am unaware of whether the committee received both appendices that were attached to the Queensland government's submission. They were referred to, but I am not sure whether they were received because, on your website, they are not attached. Are you happy that I clarify that issue through the secretariat and then update that on the web?

CHAIR—Thank you, that would be great.

Committee adjourned at 4.57 pm