COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Suicide in Australia

TUESDAY, 30 MARCH 2010

PERTH

BY AUTHORITY OF THE SENATE

SENATE COMMUNITY AFFAIRS
REFERENCES COMMITTEE
Tuesday, 30 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, Furner, Moore, 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 12.57 pm

SOMERVILLE, Mr Craig, Chief Executive Officer, Aboriginal Health Council of Western Australia

CHAIR (Senator Siewert)—Welcome. The Senate Standing Committee on Community Affairs is continuing its inquiry into suicide in Australia. Today the committee will be speaking to a number of organisations providing services in Western Australia, including many who have contributed to the development of the Western Australian Suicide Prevention Strategy. I understand that you have been given information on parliamentary privilege and the protection of witnesses and evidence.

Mr Somerville—I certainly have.

CHAIR—I invite you to make an opening statement and then we will ask you some full, searching and penetrating questions.

Mr Somerville—I am the CEO of the Aboriginal Health Council but I am also coming from the perspective of being the former Chief Executive Officer of the Aboriginal Legal Service around the time of the Royal Commission into Aboriginal Deaths in Custody. At that stage, I was also dealing with lots of families who were going through the trauma of suicide. I have also had experience as a community member of the Mental Health Review Board of Western Australia, which has now been absorbed into the Administrative Appeals Tribunal, but it is used to review the involuntary status of people in the community and in mental hospitals. That was an opportunity to reflect on and speak to people in the same area of mental illness who had been unwell emotionally and socially. Many of them were facing thoughts of suicide. I was also dealing with the families who were trying to cope with these things.

I would add that, when I first became involved with the board, I did not see many of my Aboriginal people in the institutions or even in community care. But, during the last part of my time, I was seeing increasing numbers of young people and young Aboriginal men linked with substance abuse, particularly illicit drugs.

I was also a community member of the parole board in Western Australia for about five years, until recently, again dealing with people in those situations.

Senator MOORE—Mr Somerville, with all that experience, what do you want to tell us about what you think should happen?

Mr Somerville—There are two things. We need an acceptance that support for these people is needed in the community and it needs to be integrated with their families. Many of these people appear to me to be very isolated from their communities and families, and the families are also already in difficulty and the mental illness becomes an added burden that they cannot cope with. When it leads to suicide there is this enormous sense of guilt: ‘What could I have done? What did I do wrong?’ I saw particularly when dealing with families during the royal commission that people go through shock, disbelief, blame and rage, and I saw a connection—many of the people who committed suicide during this period had close family who had done it before them. So the approach needs to be community based.

Secondly, we need to have a holistic approach. My experience is that services for people experiencing these problems are clinically and institutionally based, and I do not think they deal with people’s social and emotional wellbeing or, for Aboriginal people, their spirit and the generational issues that have come out of the stolen generation—not just for the people who were in institutions but for the second and the third generation, who are still connected to it. A problem with the institutional and the clinical based situation is that, once you leave Perth, the resources are almost nonexistent. I have had people explain to me quite simply that the only place that you can get quality services in a lot of these areas is in prison, because prisons have psychologists and assessments. Also, fortunately and unfortunately, when deaths in custody became an issue, people who were coming into custody were assessed for the risk of self-harm and suicide and they tried to deal with it. So the approach needs to be community based and holistic.

Senator MOORE—We have a copy of the fairly recent plan that has come out from the Western Australia government. Can you tell us what engagement your organisation has had and what you hope for the engagement of Aboriginal issues in this quite impressive-looking plan, in terms of the particular need for your community?

Mr Somerville—As I think was said before, we believe this is an Australian first in Aboriginal affairs because we had a real partnership between the Aboriginal community controlled sector, the state government, the Commonwealth government and the non-government sector, such as GP Network. We had regional planning forums with those partners. That forum drew up a plan which asked: what are our priorities in Aboriginal health? It then asked: what should be doing about those priorities, what is our action plan and who is best placed to do what? That meant that it became what I was speaking about earlier—community based, regionally based and holistic.

Out of the, I think it was, $117 million, $44 million was put to mental health and social and emotional wellbeing. As I understand, $22 million of that has been released to the regions for social and emotional wellbeing projects. The other $22 million was designated for a statewide approach. The difficulty we had earlier last year—before my time, so I am interpreting what people told me, but I am very confident about this—was that that was interpreted by the mental health division of the health department as needing to go to a new branch, a statewide Aboriginal mental health service. We said that that did not match what we had been doing everywhere else in Aboriginal health, and it certainly had not involved detailed planning with the regions. We said that we wanted them to find out what the priorities in Aboriginal mental health, were, what we needed to do and who would do what. About their service proposal, I said, ‘I don’t think we’re going to disagree about the range of services that might be available, but we do not accept that only a state public service agency could deliver it.’ We thought that, in terms of delivery, our community controlled services, linking with the social and emotional wellbeing money, would be in the best position to deliver and to coordinate.

Very recently, the mental health division was taken into the new Mental Health Commission. They now have responsibility for negotiating the $22 million that is still there. They have made it very clear that that commission will not be delivering direct services. At our statewide Aboriginal health conference last week, we met with the parliamentary secretary for mental health, the Hon. Helen Morton MLC. She made it very clear that they will not be directly providing services and that they will engage with us in a partnership back out in the regions.

CHAIR—So we are going back to community delivery.

Mr Somerville—Yes. We do not deny that at times acute care is necessary. Acute care might happen in hospital, in our clinics or with a GP, but we hope that will be decided at the local level. What has been released so far has our full support. There are some great projects in there, controlled by both the community and non-government and state bodies.

CHAIR—Sorry, I have interrupted you. I just wanted to find out where the other $22 million was. Of the $44 million, $22 million is going to social and emotional wellbeing—

Mr Somerville—Social and emotional wellbeing projects. The other $20 million is still sitting at the side until we decide how the statewide approach is going to take place.

Senator MOORE—What about the wider health strategy?

Mr Somerville—That is still under COAG. Mental health was one of the key strategic areas.

Senator MOORE—Within the mental health plan there is the suicide plan, which is $13 million over the next four years.

Mr Somerville—Yes.

Senator MOORE—I know that people have been involved at various levels. I am interested to know whether that engagement you have had with the wider mental health and wellbeing strategy, which you have outlined, is carried on into the specific suicide stuff.

Mr Somerville—No. I have only been doing this since 7 January. I have not had a chance to discuss that aspect because we have been so consumed with COAG.

Senator MOORE—It all links in together. There is no doubt about that. It would seem to me that, if not your organisation itself, at least your member organisations would be involved on the ground.

Mr Somerville—For sure.

Senator ADAMS—Thanks, Mr Somerville, for your introduction. Would you like to describe how your organisation did the work on the ground in Narrogin. You obviously have an ongoing commitment there. Could you tell us how you handled that.

Mr Somerville—Unfortunately, I was not the CEO back then. AHCWA took up a leadership role on behalf of the Aboriginal sector because there was no Aboriginal medical service based in Narrogin. I see Darryl is appearing before you later.

CHAIR—He is coming this afternoon, so we will ask him.

Mr Somerville—Darryl is my predecessor. He is strongly connected to the Narrogin community. If I could, I would like to defer to him. They now have formed the Nyungar Health Council, with the idea that it will be a regional body for Aboriginal health services. They have now taken leadership in Narrogin from us, but with our blessing. I can say that it was a devastating example of what a series of suicides can do to a small, closely related community. As I understand it, there is the big worry that it is spreading across the south-west now and that related communities like Albany are now experiencing it. I know that last year we were very keen that the specific cases be examined closely. Secondly, we were very concerned that there was support for the community, to provide some healing for them. We wanted to have some ongoing community based services there. I know that the South West Aboriginal Medical Service sought our support—which we provided—in opening an Aboriginal medical service sub-branch in Narrogin that will be able to extend the service. There is a huge population in the south-west. We have an Aboriginal health service in Bunbury and then we have an Aboriginal health service in the metropolitan area—Derby. But in between that it is very sparse.

CHAIR—I understand Paul Sheridan has left SWAMS. Are you aware of that? I only heard that at the end of last week. Is that true? Have you heard that?

Mr Somerville—Who was that again, sorry?

CHAIR—He is the person who was doing social work for at least the last 18 months—that I am aware of—for four days a week. He was working out of SWAMS but in Narrogin. I spoke to him a number of times and it seemed to me, from the outside, that he was doing a very good job. But I do not know if it is true that he has left. I have not had that confirmed.

Mr Somerville—I do not know. I do know that Darryl and Mick Gooda, the social justice commissioner, were down in Narrogin last Tuesday so Darryl would be right up to date with it.

CHAIR—Okay.

Senator ADAMS—I have a question on your conference last week, Mr Somerville. What were the main issues that came forward?

Mr Somerville—We talked about a lot of particular issues but the core thing was very much what I said earlier about being able to have community based programs resourced across the board in Aboriginal health and also the need to build strong Aboriginal health organisations and to provide some stability. That is what AHCWA's role is. In the past people have talked about AHCWA as a statewide body concentrating on mental health, youth issues and those sorts of things. But they were saying they would like AHCWA to be able to provide the support and the expertise so that we can build strong, sustainable Aboriginal health organisations in very difficult areas. One of the things facing our health services is accommodation for staffing. Out of Closing the Gap we have probably got a new workforce of about 400 people. We do not have any fear about having Aboriginal people available to fill those positions but those that have to come in to new areas need accommodation. The threshold in terms of income and in terms of your government housing, your Homeswest housing, is, I think, about $30,000, so people who take up positions with us are going to lose their house. It is one of the things that Mick Gooda said he wanted to look at early in his time as social justice commissioner.

Senator ADAMS—So what recommendations, if any, have been made to government from the conference?

Mr Somerville—Yes, around those things, repeating the call that that other $22 million needs to be properly planned and properly engaged with the community. There was a recommendation welcoming the new mental health commission and our government’s focus and encouraging the continuation of this partnership. There was one other key recommendation which was saying that we were worried that in Closing the Gap we have got silos. We have got closing the gap around housing, closing the gap around health, closing the gap around education and we are saying we are whole people and we are just in different spaces at different times and it is all interrelated and we have evidence—I suppose it is community based evidence—and experiences from other Indigenous nations around the world. We have our young people under the age of 10 contemplating suicide. I had some discussions with the Blood Tribe health service in Alberta, Canada. They were saying that they had data saying that something like two-thirds of people under the age of 25 had seriously contemplated suicide, for the variety of reasons that we have been talking about. So we need to be aware of what is happening to all of our people in the different spaces. We have got people in prison. We have got people in hospital. We have got people in schools. If we do not connect the information together and if we do not integrate the resources that are going in, I think we will fail to a large extent, because of the way it interrelates.

Senator ADAMS—This committee has been doing an inquiry into hearing services and we have had quite a lot of evidence from different areas. People have been saying that with the justice system 90 per cent of incarcerated Aboriginal people have some sort of hearing loss. Have you been doing any work with hearing services and could you give us any evidence on that particular problem?

Mr Somerville—No. I have not done any direct work and I am not holding direct knowledge in my mind around it. I know we are aware. It goes back to that school thing. Things like otitis media are rampant throughout our community. Young children are getting it first. For environmental and ongoing reasons in terms of lack of treatment, it will continue and then that person is going into a new space. So their hearing problem would not have necessarily been fixed and unfortunately the space they are now in is a prison. I could get you some more specific information on what is happening in the hearing area from my organisation and our members.

Senator ADAMS—That would be very useful.

CHAIR—I am wondering if there are issues around linking hearing loss and the problems that that generates with mental health. Have you done any research or do you have any information around that space in particular? We did have some evidence on it. There was an example from South Australia of where somebody who had a history of rage and interaction with the criminal justice system, in particular over assault, had been in and out of the system. He was not a young many anymore, by the sound of it, but in prison they identified his hearing loss and they started addressing his hearing problem and apparently that really started addressing some of his issues as to rage, alienation and isolation. So I am wondering if there has been any work on the issues around hearing loss and mental health in the Aboriginal community.

Mr Somerville—Not that I am aware of. I will make inquiries back at my organisation and I will see. I am aware of a lot of discussion around the fact that behavioural problems in school are related to the same thing. It has also triggered a thought in my mind, and this is moving to another area. Recently we have been building strong links with the head injured area. I was actually speaking this morning with people from Headwest, which is the representative body here. We were talking about a similar thing, the frustration that people with head injuries experience which then leads to their ending up—as in many cases—in institutions. The people were talking to me about the despair. Often these people are coming from a very functional life and are going into a life where they are highly dependent. They are suicidal. Another discussion that we had at our statewide conference was about the effect of financial stress on people and about the enormous stress in the Aboriginal community over finances, leading to things like suicide.

Senator FURNER—Mr Somerville, I want to take you to some of the evidence we have heard through the inquiry on the reliability of statistics. You referred to some statistics from overseas about two-thirds of people contemplating suicide. How reliable do you think our data in this country is in terms of the gathering of statistics on the contemplation of suicide and also actual suicides?

Mr Somerville—I am not an expert, but I think the stuff that I hear seems to me to be very sensible and very reliable. I do not think it goes against what the community experience is. Our service has got a good store of data because we are usually the only service in town and we have a community approach. Our people are out there on the street and can see it. I would feel reasonably confident about it. I have not seen anything which is masking the problem. But I am also constantly saying that if we get enough by way of statistics to raise our concern then let’s move to action. I would certainly think there is an enormous store of data for the Aboriginal sector around the royal commission into Aboriginal deaths in custody.

Senator FURNER—Just concentrating on that particular area, the WA Suicide Prevention Strategy talks about the suicide rate of men in WA prisons being five times higher than that in the general population and then goes on to talk about the higher suicide rates for people on remand as opposed to sentenced prisoners. In your experience, how many Aboriginal prisoners on remand or who are sentenced would suicide?

Mr Somerville—In my experience, and that is going to the parole board, I think you will find that there is a much lower proportion of Aboriginal prisoners who are in fact on remand because of the nature of their offences, which are dealt with probably pretty quickly and then added to their criminal record, or the fact that they are breaching things like community service orders and parole orders. But I would say that, in sentenced prisoners, yes, that rate would be at least five times higher, if not more, because of the increased feelings of isolation and separation and the way the prison system operates. To give you an example, if you are sentenced for quite a serious offence and you are a Kimberley Aboriginal person, because there is currently no maximum or medium security prison in the Kimberley you will be moved to at least Roebourne and immediately be isolated from your family, who do not have the ability to visit you. But with the overcrowding you are probably more likely to be moved to a medium or maximum security prison in Perth, where the isolation becomes even more acute. The physical environment of prison is very confronting to Aboriginal people, who have come out of an open community and family situation. That is repeated in places like Goldfields, out into the Ngaanyatjarra lands, the Central Desert area. There are a very limited number of places for more serious offenders at Eastern Goldfields Regional Prison. Families just do not have the resources to come and sustain themselves in places like Perth.

Senator FURNER—So what is the length of remand in those circumstances?

Mr Somerville—I do not have the data to back it up but I would say—again, for a variety of reasons—that in my experience Aboriginal people would be more likely to plead guilty and want things dealt with. It is a very common thing to say, ‘I want to plead guilty or have my matters dealt with as quickly as possible.’ The vast majority of offences are in the Magistrates Court. We have also still got large numbers of our people going to prison for fine defaults or for breaching community service orders. We have got people in prison because they did not pay a fine for failing to vote or failing to return their registration papers for their plates.

Senator FURNER—Senator Adams referred to the hearing inquiry in the Territory; I think that is where we heard quite substantial information and evidence about what you were just implying. I imagine that lends itself to situations where people feel depressed and suicidal. Out of mere frustration or wanting to move on and get the matter cleared, in some circumstances up there they agree to the crime and to the incarceration because of a number of things, such as not understanding what the situation was and not being able to hear what the conviction was. Would that be consistent with your view?

Mr Somerville—And there is also this feeling of despair and ‘My life is just so out of order.’ I think some people think it is a bit of respite to get away from what is happening to them in the community or from the lack of things happening to them in the community. They think ‘At least I will be going somewhere to get away from it all.’ It is tragic but I think it is true.

Senator FURNER—But your point is the added frustration of not having communication with your family or friends and of being removed from those remote locations.

Mr Somerville—And that is why the generational suicide is such a worry. If you accept that for our extended family there is grief around not just the people who are suicidal but the many funerals you go to during the year and the many people you watch die in hospital, you can understand that you just get deathed out.

CHAIR—We received evidence in the Territory that a person could experience on average up to 12 traumas in a community—and the traumas were deaths in the community or of a close family member. I am pretty certain the number was 12. Has there been similar work done in Western Australia on the amount of trauma people experienced? We were talking about it in terms of what it does to people’s social and emotional wellbeing in having to cope with that sort of trauma and that level of trauma and also what it does to community. I am just wondering whether similar work has been done in WA. Given the size of our state, if work has been done, is the Kimberley different from the south-west and other places?

Mr Somerville—I do not know the answer to that. Again, I will see what our wider network of people who have been involved in this say. I do not know what sort of research has been done on the ridge, but I have had experience in all of the regions and the theme is very much the same. Some areas are even less resourced than others. I am not wanting to assume too much, but if you are in Broome you are going to be a lot better off than in country. If you are sitting over at Mt Newman, where my people come from, it is a different story. There is just nothing there for you and there is no awareness of the grief and trauma that is going on from not only suicide but death.

Senator FURNER—You spoke about the stresses in the Aboriginal communities. If you had to prioritise the types of stresses, where would you start and where would you end, ranging from things like substance abuse, employment, isolation, housing and those sorts of things?

Mr Somerville—I would say illness in all of its different ways and also worry, particularly about new drugs and their effect on the community, followed by accommodation and then poverty—just not being able to support yourself and your family. People who were on parole were coming to the program and saying: 'I'm so worried about my family. Where is my family going to get its next feed from?' That is the other stress on them: I was at Curtin University running a very good Australia-wide Aboriginal community management course. People would come from Queensland to do a two-week block of the course and they would say to you: 'I've come here and my family has no money back home.' I had one young man crying in my office because he had a new born baby and his wife had no money for baby formula. They were not spending their money anywhere else; I knew that. He said: 'What can I do? I'm not going to be able to get home within 24 hours.' I think the stress is that things are just so fragile for people. Somebody might be in a reasonably good job now, but they have nothing backing that up. There are enormous stresses on people.

Senator FURNER—How big is the substance abuse problem in the communities?

Mr Somerville—Talking state-wide, I would say that for our people who are under 40 years of age it is enormous; it is frightening, particularly in our communities within and around the mining sectors. We have had wonderful gains with employment and economic opportunities but the movement of large amounts of marijuana and amphetamines and the like is just destroying our communities. From my experience—more so from my time on the parole board because the ALS was a while ago—it was certainly affecting most of our people who were under 30. They are a big proportion of our prison population and their reason for being there was directly related to drugs. When it comes to the under 25s, drugs are a completely dominating factor. A part of the reason for that is these people are again separated from their community and living that other subculture. Their family is now the people who live in the same subculture as them. The stresses back on the family are just enormous. You get people saying to you: 'I don't know what to do. My son' or 'my daughter is just out of control and I can't communicate with them.' So they worry and they worry and they worry and then when people are in prison they worry even more. It is driving family violence. In those places where it is endemic, it is driving child sexual abuse. And it is moving at such a pace that it is just incredible. People say to me, 'I'm going to leave my job here in Perth because I want to get out and take my kids back to community.' But we know that in the central reserve—Warburton, the north-east goldfield—there has been a big influx of illicit drugs, particularly marijuana, across the South Australian border.

CHAIR—Is that the South Australian strip?

Mr Somerville—Yes, it is coming in there.

CHAIR—We have heard reports about a community—it is talked about all the time—and its name starts with an 'M'.

Senator MOORE—The one that always misses out.

Mr Somerville—Yes. The other thing about marijuana and involvement in the mental health system is: I do not have the data in front of me, but people—for instance, the psychiatrist that I worked with on the board—are saying, ‘This is pushing your young, vulnerable men over the edge.’

CHAIR—It is a certain age group that it affects: older teens, and those up to 25; it is where their brain development is at, or something.

Mr Somerville—I have not seen him for many years or read his stuff for a number of years, but I did, back at the royal commission; have you run across any of the work of Dr Ernst Hunter?

Senator MOORE—Yes.

Mr Somerville—He talks a lot about these two high risk groups, in particular the postadolescent group, and he was drawing on some data about high proportions in the population and drawing in, I think, some South Pacific information.

Senator MOORE—And there is stronger marijuana; it is a different strength, from the different way of growing it. So the capacity of it is much stronger than it was—when I was young!

Mr Somerville—I know the hot spots. Broome is an enormous worry to us. And Broome was the hot spot for Ernst’s work; he drew that out. It has always had an enormous drug culture, particularly marijuana. You see a lot of young people—even though they are Broome people—get wrapped up in Broome as a tourist party town. So I am worried about the enormous use, right through the community there, of things like marijuana. But it is Kalgoorlie, Broome—these large centres of development. I know that the people who are distributing these drugs work on the vulnerable. Amongst our young people there is a market for them and they exploit it. We are working very hard on the ground in our organisations to raise awareness, but it is about getting to the belief amongst our young people that this stuff is not harmful.

CHAIR—We are just about out of time, and I know that you are on a tight time line. I just wanted to ask about the issues around Albany. Is it better to ask you or Darryl about that?

Mr Somerville—I think Darryl, because Darryl is very closely in touch with that.

CHAIR—There is a new organisation that Pat Dudgeon is heading up, the Australian Indigenous Psychologists Association. We heard from them when we were in Brisbane. They raised a range of issues, but one of them was the issue around—and I keep telling everyone that I hate the word—‘contagion’; that is what they were calling it. It sounds like, when a suicide occurs, the impact on the likelihood of copycat suicides is higher in Aboriginal communities. Have you found that that is the case as well in Western Australia?

Mr Somerville—Certainly. Again, going back to the Royal Commission into Aboriginal Deaths in Custody, I think they could show that, in every case of suicide, the person had had a previous direct relative—in what we call in the Western world their nuclear family—suicide, and often multiple. We have had dual suicides, too. We had one terrible one—I cannot remember the year; it may have been in the late eighties—where two young boys under the age of 12 suicided at Roebourne. And then in Port Hedland there were two older first cousins who suicided together.

CHAIR—I am not going to go to the issue of how many of the recommendations have been implemented or not because we would be here for quite a long time. But is the situation improving through the mechanisms that have been put in place? Overall, not just in custody but in community, are we seeing a reduction in the issues around copycat suicides? I do not like using the word ‘copycat’ either, but at least it is better than the word ‘contagion’. Are we seeing that reduction?

Mr Somerville—No, not yet. If these resources hit the ground at the community level, I think that people will be able to identify the risks and work with the people who are in this position, telling them, ‘You do not have to be an adult to be contemplating suicide,’ and working with the schools. As I said, it is about saying to them: ‘This is not your life. You do not have to have this life.’ This work is about the self-esteem of young people and getting them to recognise that there is a real future. I am in the situation now where I can say to a young person: ‘If you finish high school, I can guarantee you a job. I can—I can guarantee you a job. If you finish university, I can guarantee you the job of your choice.’ It is also about getting parents to carry the same message, that that future is there, and to have confidence in it.

If I could say one last thing as part of the issue of family support for young people, we have to find ways of bringing fathers back in: fathers of my generation who, for whatever reason, are missing in action—they are in prison, they are in hospital, they are dead. Children are really lacking having both their parents. Amongst my Aboriginal people, the role of uncles and fathers is so important to keep young people out of that risk group and to keep them spiritually strong.

CHAIR—Thank you very much. Your time is much appreciated. I feel we have just touched the surface of some of the issues, but it has been much appreciated. I think we could keep talking about this for a long time.

Mr Somerville—Thank you.

[1.47 pm]

KYRWOOD, Mr Ross Anthony, State Director, Western Australia, Mission Australia

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

Mr Kyrwood—Yes.

CHAIR—I invite you to make an opening statement, if you feel like doing that, and then we will ask you some questions.

Mr Kyrwood—Firstly, thank you for giving us the opportunity to come and speak today. Mission Australia is a national community service organisation with around 300 community services across the country ranging from children, family and youth to homeless services and including a large footprint in employment services. In 2008-09 we helped 300,000 people. Specifically, we are not a generic mental health service provider, but we come in contact with a diverse and complex range of clients who need support in a range of areas of their lives, often including mental health. The focus of our service is on enhancing the wellbeing of our clients' lives across a range of areas, including health, social and economic participation, and housing connection and participation.

We would argue that we need integrated responses and/or services that meet the needs of a whole person if we are to promote wellbeing, which is the language we like to use to encompass the whole person and all those issues I mentioned before. Whilst there is general agreement from governments about this principle of funding across and dealing with a whole person, current practice does not reflect that becoming a reality. As a result, we often see people getting bits of service offered to them at various points in time. Therefore, things such as fragmentation and inconsistency take place, and sometimes people can fall through the gaps of that process.

Some of you may know that Mission Australia has a strong focus on research and social policy advocacy. In particular, we hold an annual youth survey, which is probably the largest youth survey in Australia. I would like to focus today on our findings from the youth survey, with specific reference to terms e and f of your inquiry's terms of reference.

The 2009 survey was completed by 48,000 young people between the age of 11 and 24. One of the key questions in the survey was to ask young people what are the issues that concern them. Following are some of the findings. I also want to give you some quotes from the young people themselves. In the survey there is a free text option and, when they choose to, young people can put in their own comments. The issues that they picked up were drugs, suicide, body image, family conflict, bullying and emotional abuse. I want to speak on a few of those.

Drugs were of particular concern for the 11- to 14-year-olds, which is interesting because that is the age group we would least likely think of as being drug users. This appears to reflect both their awareness of the negative effects of drugs and their lack of confidence in dealing with, or being able to deal with, the issues as they arise. It appears our drug education campaigns have increased young people’s awareness but also their fear about the issue without necessarily skilling them to deal with it. This is important when we consider national campaigns around societal issues such as suicide. A 12-year-old female said:

> I think peer pressure is something that I’m quite worried about because it makes lots of those things like drugs and alcohol worse. You might say that you won’t be silly with things like that but you don’t know what will happen in different settings when you are under peer pressure.

Suicide was the second area that they identified. A quarter of all age groups, and both genders, indicated that they were significantly concerned about suicide. This does not reflect that they were contemplating suicide but rather goes to their level of concern with the issue. Many young people indicated that they had heard of or knew about a suicide, and the highly connected nature of young people—often via Facebook and other media—appears to be intensifying awareness and perhaps anxiety of the issue. I was listening in to your earlier conversation. A young person in WA could quite immediately hear about a suicide which may have occurred hundreds or thousands of kilometres away, something that was unlikely five to 10 years ago. An 11-year-old male said:

> Suicide is going around a lot in our days, so I think something should be done. I don’t know what, but something.

The next area they were concerned about was family. The survey confirms the importance of family to young people of both genders and all ages, but also highlights the deep impact family conflict can have on them. A 12-year-old female said:

> I feel that family conflict is a terrible issue that has occurred in my family and it is almost irreparable.

A 13-year-old male said to us:

> My mum and dad split up and then my dad committed suicide. I don’t want to go through that again.

The next area they identified was bullying and emotional abuse. There are a number of indications from the survey of the deep and lasting impact of bullying on young people’s wellbeing. A 12-year-old male said:

> I think bullying is a major issue because the way kids treat people is cruel and this inappropriate behaviour can cause suicide and death.

A 17-year-old female said:

> Bullying leads to self-esteem issues. When you have no self-esteem you do things and things get done to you that can either be dangerous or just demeaning.

Depression and stress was the next area. This issue of concern for young people is mainly amongst the 20- to 24-year-old group followed by the 15- to 19-year-old group. The stress was caused by a number of factors, including more difficult economic times and trying to juggle study, work, family, friends and life generally. An 18-year-old female said:

> I know a lot of teenagers are struggling to cope with pressure and stress put on them by family, friends and school and uni. I know how these stresses can cause other problems such as depression and in the worst case suicide.

There was significant awareness of depression as a major issue, the difficulty of talking about it and seeking and getting help. Here are three quotes. The first is:

> Unlike the other issues depression, suicide and self-harm aren’t widely discussed, making it even harder for someone to recognise and do something about it if they are a mate or are being affected by any of these issues.

The next quote is:

> Too many young people within my life are dealing with suicide and depression, and a lot of them feel like there aren’t many adequate services to accommodate for them or are too afraid to ask for access or help.

The final quote is:

> People are afraid to seek help concerning depression. Depression is something that still widely goes unnoticed. Particularly schools and workplaces need more information about the impact that depression can have on a young person’s life and how hard it can be to function normally when the black dog has its teeth around your neck.

What was very important in this particular survey was the question: where do young people go to get advice and seek support? We may make much comment about this when we release this report, because there is a growing perception that young people seek help from magazines and people who are famous—a whole raft of different people. In fact, the overwhelming feedback in this particular youth survey was that they go, firstly, to their friends, their parents and then, secondly, to their family and relatives. In fact, school teachers, school chaplains, professionals dropped quite considerably from that group down and then the famous, the infamous, dropped even further away when it came to young people seeking advice around what they thought were important issues in their life.

Strategies are required to ensure that these groups are the groups that are skilled up to communicate with young people when they have issues of concern. The relative/family friend group is probably not considered sufficiently, but it is an important source of advice for many young people. For example, whilst use of the internet increases with age, only one in three young adults use it as a major source of advice, compared to two-thirds who go to their parents. What are some of the things that need to be done to enhance the wellbeing of young people learnt from the feedback from this survey? The first and overwhelming one was family. Those are the people who need to be skilled up. We need to help their parents, their other family members and friends who openly communicate with young people to create skills, knowledge and ability to relate to them, especially during times of stress in their own family.

The second thing, apart from needing to review current drug education support strategies, especially amongst 11- to 14-year-olds, is that we need to learn the lessons that if we do go down the path of a national communications strategy or education strategy we do not leave, especially young people, left with a message of fear whereby they get consumed with this big thing that they are worried about that needs to be demystified and we need to understand what is going on behind that. That is very important and a strong part of what we can learn from the drug education process that is taking place in Australia.

The third point is early intervention, including supporting those who young people are most likely to turn to is critical, and I have spoken to that. Strategies to ensure that these groups are well placed to support young people through information, skill development, open communication and support to a network or other services are critical. We need peer-to-peer and parent to young people programs as well as those who are also involved in other significant connections with young people’s lives, such as relatives, family and friends. We need other groups such as teachers, counsellors et cetera to think about how they can contribute to developing the skills of the parents, of the friends and of the significant family member. The ongoing development of integrated and youth-friendly mental health services is also required. Finally, our practice and research experience confirms the importance of early intervention strategies for enhancing the overall wellbeing of children and young people. The most effective of these works with all dimensions of a young person’s life and provides integrated, holistic and community based initiatives. Thank you.

Senator MOORE—In terms of the process it seems that there needs to be education of families and friends. That seems to be an important part of the information you received from young people which, frankly, surprises me because, in terms of the interaction we hear about with young people, we think the last people they would turn to would be family. Then we get into the area of people who do not have family. Does your organisation have any ideas as to how you do engage family to talk about these things, in particular parents and grandparents and people who should have that information to talk with kids? One of the things we hear from parents is they just do not know how to raise the issues and they feel as though they are going to push kids away if they want to have the family chat, which is what we used to call it when I was a child. It never worked for me. But in terms of process what other strategies are Mission coming up with as a result of the learning that you got from the survey?

Mr Kyrwood—Firstly, I would like to make a comment that we were quite surprised by that feedback as well. We have not changed the data. It was a survey of 48,000 people and that was the overwhelming response. Maybe we need to get past some of that sort of assumption that this stuff does not happen going forward.

In terms of family engagement specifically, in our children and family process we have an example of a pretty holistic program up at Inala, Queensland, which you might be aware of, called Pathways to Prevention. The principles behind that are about the whole community engaging with the whole family and building that relationship together. Mission Australia tends to play in the space where the clients who come in and spend time with us are probably in the cohort that is not representative in the youth survey, so that is 48,000 people right across the board. Generally speaking, the people that Mission Australia work with have already had some sort of identification with a system that is around of some sort, whether it is a child protection system or a mental health system or a drug and alcohol system. So to build the Pathways to Prevention principles is a bit easier because you are not necessarily trying to encapsulate the whole of the community. Mission Australia is probably overt in the last 12 months with its step into trying to move into the early intervention space and build relationships with parents, and educate as to that, through the changeover or the purchase of child care through Mission Australia Early Learning Services and of course the recently announced GoodStart program, which aspirationally is all about building relationships and the interface where the parents and the children can act together and then provide a whole connected process where we can talk to the family about what is going on in their life.

What we are anecdotally experiencing is that a parent who might come to a childcare centre would, in their busyness, like to know what is happening with little Jenny or little Johnny but there is not the infrastructure to actually create that relationship. I think where that happens is with some of our best childcare centres in Australia. What we are looking at doing is trying to build a structure whereby, you have, if you like, a community engagement or community worker whose actual role is to be engaged with the interface between the family and the childcare experience. That is so that when you build a relationship of trust you can then have the conversations that mum or dad might want to go to someone else to talk about. It might be around: 'How do I build my relationship, not with the young person or the child or the infant that is in the childcare centre but with my teenage son or my teenage daughter?'

What we are trying to do is identify a relationship with families as early as possible, through child care, and build into that a role which is about connecting the issues that are happening for the family, which take place inside that childcare centre. It can happen through conversation or it can happen through observation of what is taking place for the child during the care experience. So it is about relationship, it is about passing on good information and it is about allowing a conversation over a period of time to take place. What is the big difference in our thinking around that? A lot of information gets given in a pamphlet, it is one way and you do not get to ask questions and you do not get to trial it and find it did not work and come back and check again. The models we are looking at in the early years are around having that relationship where conversation can occur over some period of time, not just in one session.

Senator MOORE—Some of the most confronting evidence that we have had in this inquiry has come from families whose child has committed suicide and they have absolutely no idea why. In fact, they have in some cases, as a result of the pain that they have suffered, gone into a more discursive role, so they go out and they talk with people about what happened, to prepare others for what could be warning signs—but consistently through SPA there are often no warning signs and that is one of the horrors. If you had a little roadmap that showed you that these are the signs to look for, that would be good. But in many of these cases there are none. So within that framework is that something that is actually being addressed within places like yours, to work with families that have gone through this process to see what could have gone wrong and if clearly there is nothing that has gone wrong then working with families who are trying to rebuild their own family post the horror of losing someone, particularly a child?

Mr Kyrwood—I think I made the comment in our opening statement that we do not have specific suicide programs that we are running. Suicide occurs as it does in the community in the life of our community as well. Our programs are built around case management models that see the family engaged. We will continue that process of building a relationship with the family, connecting with that family and helping that family to go through that grief and loss process. I might not be answering your question. That is if you do not mind me taking it another way.

Senator MOORE—That is fine.

Mr Kyrwood—I think some of the solutions as to this, and this is picking up on your other point that it is the families who do not know, concern the families who know how to successfully build that relationship with their children and their young people. What we often do is connect together the people who have gone through the grief and through the loss. We need to work out ways to cleverly connect those who have actually built the relationship—so these are those that we never hear of—who through a relationship have actually connected with their children and who may have gone through a mental health episode or episodes or have a mental health issue and have successfully transitioned through those sorts of experiences.

I think, significantly, parents are wanting to know: ‘How do I build that relationship with my young people?’ We need to offer them solutions that do not put them in judgment. It is like when we do our early years stuff. Again, you do a simple assessment. Research will tell you that a parent will always over assess how well their little Jenny or little Johnny is going because there is a whole lot of emotion connected to that sort of stuff. What we need to know is: how do we champion and connect that, where families are doing it right and are engaging with each other? The majority of this survey, which is across the population, is saying that young people are still going to their parents, to their family and to their friends to get their major support and advice—not even during crisis; just during process.

Senator MOORE—That is certainly not the evidence we have had. That is the first element of evidence that says that. In fact, consistently, just about every other core organisation that has come to us said that, for many young people, that is the last place they go to. For the ones who can, that is great. It really is a remarkable achievement to build a family relationship that is that strong. It is good to have an alternative view.

Mr Kyrwood—The message we are trying to give is that the majority of young people are amazing contributors to our society. Our observation of that comment would be that we often hear about the percentage who are finding it tough. We do not hear about the majority who successfully transition through school. The majority of people actually go through school, go on to full employment and contribute generally.

Senator MOORE—The link I would like to make will not be in this survey because it is one and two in the whole process. Young people have identified through the survey that suicide is one of the core things that is a concern for them and they have identified somewhere else that their family are their source of information. I would like to know how those two things work. If they are already saying in the survey that, yes, it is drugs and suicide, I would like to investigate a bit more to find out if it is that issue. They have said they go to their families. How, when and what response do they get? That is not a simple answer; that is the next step.

Senator ADAMS—I would like to take you back to the 10- to 14-year-olds and the use of Facebook and the internet. How influential do you think the internet is with this group of children, especially ones who are troubled and not able to cope?

Mr Kyrwood—I have a couple of comments on that. There is no doubt that the internet—Facebook, MSN and that sort of stuff—is a highly used communication tool for young people. That can be a positive or negative experience for young people. As for it being a mechanism to connect, get to and educate, I think there is some relevance there, although I often think that the cohort of people that we are referring to—the cohort of people who come through our drug and alcohol services—are aware of the internet and know how to use it but they do not actually participate in the Facebook type of stuff. Their life is in too much chaos and too much crisis for them to engage in that type of activity. They will go in and out of it. It is in their world, but it is not the mainstream. That is up against the image that we have of a lot of teenagers who are Facebooking and communicating predominantly through that type of mechanism. I think we have to separate the smaller cohort of people whose lives are chaotic and in crisis—they may have mental health issues or drug and alcohol issues or a whole raft of stuff—from the larger cohort of people who are just engaging, going with the trends and participating in community life. For them, internet communication is a large part of that activity. What was the second part of your question?

Senator ADAMS—What I was trying to get at was that suicide was mentioned and you commented that, instead of 12 people within a class or a small community knowing about it, the fact is that the users of Facebook communicate with a huge population. It just concerns me a little bit. Are we going into an area where a child may not have been touched by suicide or even have any thoughts about it, then they get into this and read all these stories? Some may be true and some may not be. There are different experiences. We might end up then with the copycat thing. I am just wondering, with such a large survey—as you said, it was 48,000—if there is any evidence of the internet being a tool that somebody who did have those problems would use to follow through.

Mr Kyrwood—There is no doubt that the speed at which communication occurs and how quickly you can be connected means that young people are more aware and connected with what is going on with suicide. Whether that has perpetuated—and I pick up your point about what is the right language here—copycatting, our research has not covered that and I do not know whether the research has got to that. There is no doubt though that people's awareness of suicide happening amongst young people is greater than when they are more isolated. There is no doubt about that.

Again though, one of the interesting things around where you go for advice is that the internet is where people go as they are getting older, so there is a shift to the internet, if you like, or Facebook as a communication strategy for someone to engage or relate to, or talk about what happening in their world versus a point or place where they go to try to find advice. Our research indicated that that shift started happening once they got to the older age groups—20 plus—when they go off to seek information and advice. It is not necessarily where the younger cohort is going to seek advice about feeling depressed or sad. It is certainly a place they communicate those messages to one another, but it is not necessarily where they would go. That is the interesting data that has come out. It is not where they go. They are still going, as they told us in this survey, to friends.

Maybe what needs to be further researched in that connection with friends is the mechanism to go to friends. Is that a conversation face to face or is it a virtual conversation? They are still going to friends and that is the key. How they communicate with one another, I guess, is a mechanism that changes as time goes on. But it is friends, parents and family they go to for key pieces of advice.

Senator ADAMS—Was the survey done online?

Mr Kyrwood—Online through schools, with hard copies, et cetera. It is eight years old—

Senator ADAMS—As far as rural and remote communities, how have you communicated? Did you get many replies from those areas?

Mr Kyrwood—I do not have the exact breakdown across those, but I do know that in WA, for instance, amongst the 5,000, there were a number of schools in remote and regional areas that participated. One of our key strategies to get the surveys completed is to go to schools and the schools, if they submit 250 responses, get their own data so they can actually break it down and find out what their own cohort of students is saying. So that is a bit of an attraction for schools to pick that up and engage in that and that applies to both regional and remote. It does also identify Torres Strait Islanders and Aboriginal and nationality groups, but I do not have the breakdown of that data. I have the whole report with me, if you would like it.

Senator ADAMS—If we could have it tabled we would be very interested—

Mr Kyrwood—To be honest, it is report that regularly gets used from a youth policy perspective. It is a significant document in Australian life.

Senator ADAMS—As far as WA goes, looking again at rural and remote, how many people have you got working? Are they working in teams? Exactly how are they working in smaller communities?

Mr Kyrwood—The service footprint in Mission Australia in WA does not go into regional and remote Western Australia currently. We are heavily involved in employment. Changes to contracts and the awarding of contracts changed that around. At the moment we engage in areas where we are able to get funding to do those sorts of services, and that is predominantly through government contracts. So we just do not go off and do a new service in an area unless we have either got corporate funding or win a government contract to deliver that work.

Senator ADAMS—So who is delivering that work then at the moment?

Mr Kyrwood—There is a whole raft of services, and I would imagine that a number of those services are the ones that have submitted to your inquiry.

Senator ADAMS—As Mission Australia has got such a breadth of experience across all states, is there any way that you communicate with all these other non-government organisations on issues?

Mr Kyrwood—Yes. We have participated in doing that on a number of levels. Let us start at the bottom level, which is simply around service delivery to a group of people or to an individual, so that is around building a network with a different group of service providers. In fact, Mission Australia uses a tool—this outcome hierarchy—which identifies what research has told us are key areas that we must work with to help people experience a fairer Australia, which is our vision, through our core areas: children and family, youth, homelessness and employment. Research tells you that there are key things you must work on in a person’s life, which I alluded to in my opening comments. If our service delivery is unable because of finances to deliver on all of those areas then we build a partnership with another provider who can build that type of stuff into the service offering that is taking place for a person or a young person.

Senator ADAMS—How is an evaluation of that partnership done, or when is it done? How many years do you let something go as far as a partnership is concerned? If it is three years, the contract is out there. How is that evaluated?

Mr Kyrwood—Evaluation happens for us in a number of levels. One is that we have our internal quality tools which look at what outcomes we are producing in the particular service we are offering. So, if it is a drug and alcohol service, an employment service or a housing service, we have a whole raft of internal tools that we use to measure those sorts of things. And then, as I mentioned earlier, a number of our services—in fact, a large percentage of our funding—come through government programs, so we sit within the framework of a government program being reviewed and assessed. As an example, Job Network is reviewed on a federal level, the outcome is a new structure which becomes Job Services Australia, the whole thing gets tendered for and then you go for that tendering process. That changes where your footprint exists because the awarding of the tender comes from another source.

In terms of the evaluation of these things, part of the difficulty—and it goes, I think, to the fragmentation that we alluded to earlier—is that you have a whole raft of programs, which might be on employment, mental health, housing or drugs and alcohol. We have buckets of funding that come into these processes. We have a whole lot of compliance. We have a whole lot of activity around telling people how we are spending the money, but we are not asking a lot of good questions around how all those buckets come together: are they achieving a better whole? Are they achieving a better outcome?

What also takes place is that, because these things get awarded in different styles depending on how the government or the government department chooses to implement these things, you start going down a path and all of a sudden that gets reviewed somewhere else. You may be a player and then next contract you may not be a player. A new player comes in and has to restart that relationship all over again, often without people knowing why they won or lost a particular piece of business or necessarily understanding what impact that has had on a client group going forward. When we talk about fragmentation, they are the examples of that fragmentation taking place.

An organisation might see a need in a regional or remote community. It may be successful in building a partnership with a corporate, but, if it is reliant upon a government source of funding to come in and do that, it really has a very limited chance because all you can do is advocate, continue to put up that need and hope that what pops out is an opportunity to get funding for that particular program in that particular community. So how you do your needs assessment and how we check these things out is connected to that issue around fragmentation.

Senator ADAMS—Thank you.

Senator FURNER—Just going to the survey results, what were the sex demographics between male and female in the return? We have taken your report.

CHAIR—It has been quite fascinating, actually. We have been looking at the different responses from the different age groups.

Mr Kyrwood—I think we will try and give you a highlight of the issues that came out of the report in connection with your inquiry on suicide. A strength of this particular report is that it does break it down into that sort of tight detail. We try to get away from those absolute assumptions and generic comments. I can best answer your question by saying that I do not know if you are flying back on a plane soon but, if you are, perhaps, if you want to read this and have a look at it, that is the best way to go. I can give you some very quick examples. Eleven to 14, with 23,859, was 51 per cent of the responses; 15 to 19 was 21,000, at 46 per cent; and then 20 to 24 was the remaining 960. There was a 52 to 47 split of gender, with females being 52.4 per cent.

Senator FURNER—Can I just take you to some of the responses you referred to in your introduction, starting with bullying, emotional abuse and, in particular, self-esteem. Were you able to disseminate any information about self-harming and that sort of issue?

Mr Kyrwood—The survey is intentionally not designed to drill down too far. It is designed to identify the issues. From memory, there are only 20-odd questions, predominantly because if you have many more than that then you do not get the participation rate. It identifies the issues. It then causes people to investigate those issues further. This becomes as much an advocacy and policy piece as anything else. A good example there is the Commissioner for Children and Young People in WA, which would use this as a key tool to go away and look at specific issues and ask specific questions. We are very aware that the Office for Youth use this as a major resource to identify where they might go off and do further exploration.

Senator FURNER—The 11- to 14-year-old bracket had an awareness of the fear of drugs. Was that where you were coming from?

Mr Kyrwood—Yes. Amongst the younger age group their concern is not that they are using; their concern is the impact of use. It could be their parents using, people around them using and what they see as use. As stated in some cases and implied in others, there is a fear around this. The attitude is: ‘What do we do about this big beast called drugs? What do we do when it comes, when we are faced with that, if it is not happening for us already?’ Do you understand what they are saying there?

Education has been fantastic. We are not saying that education is the problem. The problem is that it has not gone far enough to equip young people with the tools so that they do not have to be fearful. Often that is about the short, bite-sized bits of information you get about drugs. The education programs that take place in the schools in Western Australia perhaps do not go far enough to have the conversation, especially amongst 11- to 14-year-olds, that asks: ‘How do you feel about what you are hearing? How would you go about dealing with this? What do you do when you see Mum or Dad drunk at home? How do you engage in that sort of stuff?’ It is not getting down to that. It is simply giving a very—respectfully—vanilla, factual education. It is saying, ‘Drugs do this to your system physiologically,’ or ‘The impact on society if you use drugs is this,’ and it talks about violence and a whole raft of bits and pieces. Yet many young people see their parents using drugs without violence, having fun, so it is a mixed message for them.

Senator FURNER—When did you first release the survey?

Mr Kyrwood—Eight years ago. It is an annual survey, and it has been going for eight years.

Senator FURNER—So the 48,000 is from—

Mr Kyrwood—It is from 2009. The 2010 survey is to be launched this week.

Senator FURNER—What changes have you seen in the eight years?

Mr Kyrwood—The overt change over the period of time is where body image falls. Generally speaking, the issues I spoke to have traditionally always been the top issues identified. For a number of years, body image, especially amongst females, was such a large response in the data that it put it as the highest issue, even though drugs came out as the highest statistical issue. When you read the data, it is very important that you cannot interpret drugs, alcohol, bullying or suicide as an overly obvious issue. They all sit around the mid-20s to 30s percentile. We are not talking 70s, 80s or 90s responding in this way. We are saying that 20 or 30 per cent of the group are indicating this. That is where they are getting the common messages from.

CHAIR—Can I go back to the issues around fear. You were talking about not instilling fear. I think I may still be misinterpreting what you are saying. Are you saying that you want to make sure young people are aware of drugs and how they can affect them but that you do not want them to be fearful about challenging others if they are being pressured to try them? Is it about them having enough confidence to be able to say no or to seek help? I am just trying to work out what you mean by it. I am still not quite clear about what you mean.

Mr Kyrwood—What we understand they are saying is that they have a lot of information but they do not necessarily feel that they are equipped to make the decisions themselves or to deal with the situation around drugs, if and when it presents itself to them. So ‘a fire is very hot,’ is followed by, ‘I am very scared of a fire’, not ‘therefore I do not go near it’ or ‘I stay 10 steps away from it’ or whatever. It is a very simple illustration, but it is more that second part that is a strong message.

CHAIR—In other words, they lack the confidence to deal with that situation. Is that right?

Mr Kyrwood—Yes, and that could be because of their age, 11 to 14. It could be that the education is not going far enough to have that conversation with them—that that last part is lacking in what we are implementing. So the linkage we are trying to make is that, when we talk about suicide in our society, we have got to be careful that that conversation goes beyond just information around suicide and where to go for help; there needs to be some sort of engagement around it: ‘What might you do when either you have some sort of thought or something happens in and around your friends or your family? What would you do about that?’

CHAIR—We have only got a couple of minutes left, but I just wanted to ask you a couple of questions about something that has come up quite a few times, and that is how you talk about suicide with young people in particular. People have said to us that some people say—I do not think anybody has actually presented evidence to us of this—that you should not talk about suicide with young people. Youth Focus—and I do not want to put words into their mouth, because they are coming tomorrow—have said at Parliament House, talking at a parliamentary breakfast, for example, that they have been trying to get more education into schools but they have had some opposition from some schools because of the fear that talking about suicide with young people will put the idea into kids’ heads. It sounds like there is a similar sort of issue with drugs. How do you talk about it so that people feel confident about dealing with it?

Mr Kyrwood—Correct. I think that is the other important point here, and it is one of the difficulties, I guess, in our observation and our system. Educators are employed, trained and equipped to be educators, to do the basics of an education process, yet they are a cohort of people who have an interface with young people every single day. The interesting challenge we are putting into this debate is: if friends, family and other relatives are the people that young people tell us they go to, yet the teachers are the ones engaged with them, how do we connect those three groups to get a better outcome? Therefore, if there is resistance from schools about bringing that in because it perpetuates copycatting or whatever might be the case, I think we have got to get way past that and say, ‘This is a young person and we are educating this person, and that education is both an academic process and a life skills process, and we somehow need to integrate those.’ Is it the teacher’s responsibility to be the life skills teacher? Interesting conversation, big debate—some teachers go into that space; other teachers do not. But the reality is that if we have got an integrated community it will happen through that process.

CHAIR—I do not think the evidence we have had today was saying that teachers should be doing it.

Mr Kyrwood—No.

CHAIR—It was more about getting specialist programs. For example, Youth Focus want to get into schools to present the information.

Mr Kyrwood—Exactly. And what we have been arguing is that the program does not happen without the family, friend or a significant other being part of that program as well, because that is when you start building that conversation in the relationship. We often have parent interviews around English, maths, science et cetera—that is my age of language; I know it has all changed now—but we do not necessarily talk about those other issues that might be happening in the interface that is taking place and what we are seeing in the school when we have those parent interviews.

CHAIR—Okay. We have run out of time. Can we get that survey information back from you?

Mr Kyrwood—Certainly. I am happy to send more, or it is on the internet, ironically, on Mission Australia’s website, if you want to look at it.

CHAIR—One thing I did notice is that as the group gets older they are more likely to use the internet to seek information.

Mr Kyrwood—Yes.

CHAIR—Thank you very much.

Mr Kyrwood—Thank you very much.

[2.30 pm]

CALLEJA, Mr Joe, Chief Executive Officer, Richmond Fellowship of Western Australia

MAHBOUB, Ms Lyn, Consultant, Hearing Voices Network Australia

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Ms Mahboub—The Hearing Voices Network Australia is auspiced by the Richmond Fellowship.

CHAIR—Thank you. I understand you have both been given information on parliamentary privilege and the protection of witnesses in evidence. I invite either or both of you to make an opening statement and then we will ask you some questions.

Mr Calleja—Perhaps I will start. Thank you for the opportunity to present to your inquiry. As I explained to Owen when we spoke, I think it was last Wednesday, Richmond Fellowship is not an agency that specialises in suicide or youth suicide; we are an accommodation and community outreach agency in mental health and we work with people who have experienced mental illness, and that brings with it, on many occasions, a predisposition to suicide, self-harm and so on. Any inclination or concern around suicide is part of the work that we do in our approach to recovery.

I must apologise for not having put a written submission in. We had an interesting time with the storm last week. Not only did the power go out but our server was blown out, so we did not get back onto the internet until Friday afternoon. I will put these notes in writing to Owen and you will be able to read them at your leisure.

Richmond Fellowship in WA has been in existence for 35 years. As I said, we provide both residential services and community outreach services. We have a philosophy which is based on the belief that people can and do recover from mental illness and we believe fundamental to that is the hope that exists for recovery. I underline that comment because there is a lot of literature around that actually demonstrates that if a medical practitioner—for example, a psychiatrist, a doctor or whoever—actually does not believe a person can recover from mental illness they by and large tend not to; they are maintained in their illness. The relationship and supports that are built around a position where there is recognition that mental illness is episodic, there are many factors that contribute to it and, on that basis, a person can recover are fundamental in the recovery process.

Five years ago Richmond Fellowship had contact with Ron Coleman from the UK, a Scottish mental health consultant and trainer who himself spent 13 years in the psychiatric system in the UK, six of which were in a series of locked wards. When he came to Australia he encouraged Lyn Mahboub, who is a consultant with us, to set up Hearing Voices Network Australia. We took on that view. Our board very courageously decided to do something that flew in the face of traditional psychiatry and mental health services in Australia. We did it in a participative, collaborative way but it was a fairly significant step.

What I would like to do today is to speak primarily about our experience of that and why it is important in looking at suicide in Australia. Then Lyn—who was a previous director of the Hearing Voices Network Australia and who is here today because Marlene, the current director, is away—will talk from her own perspective and the perspective of broader consumer issues and carer issues. What I want to focus on is the fact that we have had a number of groups running over the last five years, building up slowly, and in the last six months we have been trying to evaluate the impact of those groups. So we have had a questionnaire issued to participants of the groups and we have had 36 responses. That is a small sample, but these are 36 personal, real-life experiences of being involved in Hearing Voices groups. I want to run very quickly through them because I think it is the voice of the person that it is important for this inquiry to hear.

A Hearing Voices group is a group of people who hear voices who come together and exchange their knowledge and information and experience about hearing voices. In other words, they do what traditional psychiatry and mental health services say not to do, which is to talk about it. We asked them the question, ‘What benefits do you gain from participating in the group?’ Twenty-two of the 36 said, ‘I feel understood.’ Twenty-three said, ‘I feel less isolated.’ When you are talking about depression and suicide, isolation, being not understood and so on are factors that are in the mix.

The second question we asked them was about what changes they had experienced since coming to the group. Eighteen said that they heard fewer voices; 15 said the voices became more positive; 21 said they had fewer admissions—that is pretty significant; and 27 said that they had less need for emergency help. So in terms of recovery that is pretty powerful stuff.

The third question we asked them was what, since starting the group, they had become better at. Twenty-four of the 36 said that they had become better at doing things that they liked or enjoyed, so their experience of life was improving. Twenty-seven said that they enjoyed more being with other people—reducing their isolation and building social interaction. Then we asked them questions about changes since coming to the group. Thirty-one out of the 36 said that they were a more confident person. That is pretty significant given the debilitating effect that mental illness has on people and their capacity to communicate, interact and so on. So that was really significant. Then we had a whole list of individual comments that people made, and when I provide the text of this all of those comments will be available.

I will now summarise some of the things that came out of that evaluation and the implications in relation to actual research. In summary, there are a number of themes that emerged strongly from this study. The percentage of respondents personally asserting benefits of their participation in Hearing Voices groups, in each of the areas, were presented: reducing isolation, 64 per cent; enhancing feelings of being understood, 64 per cent; needing fewer admissions, 58 per cent; less emergency help, 75 per cent; improving voice-hearers’ capacity for being with others, 75 per cent; being able to speak about their voice-hearing experience, 67 per cent; increasing capacity for participation in activities that they enjoy, 67 per cent; and increasing confidence, 86 per cent.

The broader suicide research shows a strong link between depression and suicidality. Authors such as Davila and Daley in 2002 identified depression as clearly a risk factor in suicidal ideation, attempts and completions. They cite numerous studies in support of this assertion. In light of this, the central role in improving social functioning and reducing isolation that the Hearing Voices groups have been found to provide can be understood to be potentially protective against the worsening of depressive conditions and thus perhaps to reduce the risk of suicide in a predisposed individual. Given the link between stressful events and problem-solving deficits in the formulation of depression—Nezu in 1987 made that observation—the fact that groups are reported to increase coping strategies and enable sharing of the burden can be theorised to additionally be of assistance in lightening the depressive load. So it is that relationship between depression and suicide that these groups are actually getting to the pointy end of.

The Suicide Prevention Resource Centre in 2001 asserted the importance of strong connections to community support and problem solving as being protective factors against suicide, while hopelessness, relational or social loss, isolation and stigma associated with help-seeking behaviour are all identified as risk factors. So instead of closing people down these groups are opening people up to help. There are others who emphasise the varied nature of these factors and the need to explore individual as well as environmental characteristics, including those of cultures.

We believe that Hearing Voices groups are an effective way of voice hearers experiencing community support and we have found them, in this small study. to be of great assistance in providing hope through the sharing of experiences and enabling the development and sharing of workable strategies for living with a greater sense of control and power over what are disturbing experiences. This increased control enables a greater sense of hope in a future that is not dictated to and dominated by the presence of debilitating and all-consuming symptoms such as the hearing of voices or seeing of images that others do not hear or see.

So that is a snapshot of our research. I will be able to table another document—when I email Owen the findings of this brief research—which shows that our findings correspond in mirror image form to other research that has been conducted around working with voices over the last 20 years in the UK and mainland Europe in particular. I would like to leave it there. Thank you.

Ms Mahboub—Where to begin? I will tell you a little bit about me and talk a little bit about the network and, obviously, then invite questions about anything I say. I have got a background in nursing and psychology and I have worked as a program manager for Richmond Fellowship and, as Joe said, in setting up the Hearing Voices Network. I also have a lived experience, a diagnosed mental illness, and I have been on a journey of recovery since I was about 16. I began in those early days seeking strategies for, I guess, self-help—helping myself learn how to live with the difficulties associated with that. In terms of suicide, I have been hospitalised for suicidal ideation at different times. So I guess what I am saying is that I speak from experience in a number of areas, including my own life—and I am not precious; I am happy for you to ask me any questions about that.

I think suicide and what that means to an individual, how that occurs in one’s mind and the thoughts associated with it are so important to talk about. The Hearing Voices groups and the message that that the Hearing Voices Network bring to clinicians as well can support not only the people who attend our groups but also clinicians to assist in this process. The Hearing Voices Network has a two-pronged approach, and part of it is about supporting other associations to run their own groups, plus running groups within Richmond Fellowship. But it is also about teaching this approach to the whole community and mental health sector. As you heard from Joe, this sort of work has been going on for 20 years in Europe, but we are only beginning the conversation in Australia, and there are a number of places around Australia that are doing this kind of work.

The idea of the Hearing Voices Network is, hopefully, to be able to in the future bring the other states together to have a national approach to this idea of sharing information about things that are typically not spoken about. As Joe said, one of the things they used to say in the past, especially when I was nursing, was, ‘You do not talk about what people are experiencing because you might buy into their reality or their delusion.’ The fact is that you walk out and go and have a cup of tea and the person is left with that experience and are still living it. Being able to talk with other people who are having those kinds of experiences so often brings about immense relief. For example, I experience suicidal thoughts, perhaps sometimes on a monthly basis, but they do not actually mean anything. I have come to interpret them in a way that takes the sting and the impact out of them. By sharing these kinds of experiences and ways of coping with difficult thoughts and difficult voices and visions you are reducing the stress that the person is experiencing and reducing the isolation.

In the consumer movement we say, ‘ITE, I am the evidence’, even just in Perth, with the amount of people that have started to come to the groups and whom you see later on. My colleague who is on holiday at the moment and could not be here was in one of the first Hearing Voices groups that I ran; I ran one of the first ones here in Perth. She got so much benefit out of the group that she said, ‘I want to start doing some bits and pieces.’ So we said that we welcomed volunteers, and she came on. She was also a client of Richmond Fellowship at the time. She came forward as a volunteer and then she pushed me for some work. She said, ‘Right, I want a job.’ I said, ‘I will work on Richmond Fellowship and see what we can do,’ and she now runs the Hearing Voices Network; she is the coordinator of the Hearing Voices Network. You hear stories like that all the time and everywhere.

I have been blessed to go to international conferences in Scotland and in Denmark, speaking with voice hearers, staying with voice hearers and hearing them talk about their experiences of suicide, feeling suicidal and the overwhelming distress of living with these kinds of experiences all by themselves in their own minds. Within the traditional mental health system, if they go and begin to talk about those kinds of experiences, because this has not been a shared language what initially happens is that people are given more medication, so they therefore feel more drugged and are paralysed from actually dealing with the experiences they are having. Therefore, they often do not talk about them. In Voices groups, they are able to talk about them, they are able to find some sense in their experience and, as I said, they are able to reduce the feelings that make somebody want to end it all. Oftentimes we do not necessarily want to stop living; we just want to stop the pain, so we actually assist people to find new ways of dealing with it.

I will stop there. We welcome questions.

Senator MOORE—There was a guy from Scotland who was out here a few years ago, wasn’t there? I am pretty sure that I heard him at one of the seminars you ran—and he was extraordinary.

Mr Calleja—That is right.

Senator MOORE—Yes, I am sure I did. We heard evidence last week from a parent whose child had schizophrenia and went through a series of incidents. He explained the pain that she expressed when the medication she was given took away her voices. She actually felt lonely, and no-one had prepared either her or her family for the impact of her not hearing the voices. Is that something that your people, when they sit and talk about their own experiences, express to you?

Ms Mahboub—We have heard it a number of different times in different ways. I want to say at the outset that the Hearing Voices groups are not necessarily about stopping voices; they are about assisting people to learn to live with them. Sometimes, as a result of the work they do, the voices do stop. It is interesting that the people who I have spoken to in Voices networks whose voices have stopped have not been as distressed as perhaps others have. I heard of one little old lady within the public system who heard voices. She had no other supports or networks around her in the community, so her voices were her friends. What they forgot to ask her was: ‘Are they friendly? Are they positive voices?’ because that is a really good indicator for recovery. If you are getting guidance and support and then that is taken away—and for her the medication did work and it did silence the voices—you can, as she said, become terribly lonely. It is another indicator for looking at the bigger picture, because we are not just dealing with what some people might call pathology; we are dealing with a person’s whole life and their relationship to it.

Senator MOORE—Is the mainstream health system still not supportive of the process?

Ms Mahboub—We have had some really positive experiences for the most part. I said I ran one of the first voices groups, but the first voices group that started was actually in a clinic down at Rockingham mental health services. I understand there is a voices clinic at the Fremantle services. I am yet to have a chat with the people about what they are doing there. Often times in the training that Richmond Fellowship runs there are loads of clinicians who are really interested in learning more. So I think the difficulty is often that there is not a lot of money in the training budget allocated to the mental health systems. Of course, you hear that from everybody I am sure, but we want to spread the word that there is not a lot of money.

Senator MOORE—Why has Western Australia been such a leader in this area? We have just skimmed the information you gave us but it seems that a lot of this has been tried, operated and centred in WA. Is that a fair comment?

Mr Calleja—Yes it is. I would say that part of it is that I have a very brave board who are prepared to be out there and do what they feel needs to be done. We did some fairly careful work at the beginning. I went and saw the chief psychiatrist in the mental health division and said, ‘You will have heard that we are setting up this voices network. I just want to reinforce that we are not anti medication and we are not anti psychiatry,’ because those were the sorts of things that were going around—Richmond Fellowship had lost the plot and so on.

Senator MOORE—I have heard that a few times!

Mr Calleja—Really it was just that we happened to be the organisation that was prepared to take that step.

Senator MOORE—When was that?

Mr Calleja—October of 2005. The 30th anniversary of the Richmond Fellowship was the day we launched it.

Senator MOORE—Was that when Aaron Groves was the chief psychiatrist?

Mr Calleja—He had just left.

Ms Mahboub—He was not the chief psychiatrist; he was the director of mental health.

Senator MOORE—We stole him in Queensland and I have had a discussion with him about this very thing. We have not been able to break through in Queensland yet.

Ms Mahboub—Part of the original story was cultivating recovery champions and it happened in a university. Exposure to Ron Coleman happened academically and Richmond Fellowship took the step to invite Ron out here. I have to say it is only because of recovery champions like Joe and the board that these things have been able to happen. It takes this sort of leadership to be able to start those conversations and take up the challenge of bringing somebody out from the UK. I am on a stakeholders multidisciplinary group at one of the universities here where we are building a curriculum for a mental health postgrad course. I said to one of the people on the committee yesterday, ‘You had been doing recovery and this kind of thing in the UK for a while; can you tell me a little bit about how that started there.’ She said, ‘Ron Coleman was the catalyst.’ I guess that is part of it. We were lucky that he came here and assisted us and did lots of work with our organisation. That is how it happens.

Senator MOORE—My last question is about funding. It seems that you were getting some funding from different sources for a while but now that is not happening so you are having to fund it through Richmond Fellowship. Is that right?

Mr Calleja—That is correct. We are very fortunate in Western Australia to have Lotterywest, which we put a proposal to about the Hearing Voices Network and said we would like to start this in this state. Their act of bravery was to fund us for something that traditionally would not be accepted within the system. They funded us in two parts. They funded us for 12 months to enable a number of groups to be established. Then they gave us a second lot of funding to build on that and to hold a major conference as part of the second year called Recovery from Psychosis. I did send Owen the DVDs from that conference because we had 18 speakers from Europe including Marius Romme, the psychiatrist who started the hearing voices groups. So Lotterywest funded us for what ended up being close to three years with the two lots of funding. They cannot provide recurrent funding and so their funding finished at 30 June, but our organisation has made a decision to keep funding it and we will now keep looking around to see if there is any opportunity for recurrent funding. But we are committed to keeping it going anyway.

Senator MOORE—Under the new state mental health plan and the suicide plan that is linked to it, your state is the only state that has a minister who is focused on that, which the Western Australian government deserves great praise for doing. Has there been any interaction with them in terms of seeing whether that would be a program that they could support?

Mr Calleja—Minister Jacobs actually launched our Hearing Voices Network website—the upgraded whiz-bang website—in August last year. So he is aware of it. We wrote to him not long after that asking whether there was any possibility of funding. He wrote back saying, ‘No, I am sorry; we have got no money,’ but that is what bureaucrats would tell him to say. We will keep the dialogue open with the Mental Health Commission. We believe eventually that the Mental Health Commission and the equivalents in all states of Australia will see that in fact this is as important and legitimate a strategy as other funded strategies.

Ms Mahboub—I just want to add that, although I do not know what the statistics are, the suicide rate for people diagnosed with schizophrenia is huge. The support for people with that diagnosis just is not there. You would have heard from carers I would imagine who are pulling their hair out wondering what to do. It is so important that that level of support be given at some stage.

Senator ADAMS—You have communicated with the minister, but what about the parliamentary secretary, Helen Morton?

Mr Calleja—We have had a fair degree of communication with Helen. She is very supportive and always has been. Minister Jacobs is supportive as well, but he does not write the cheques. We have experienced support from the division as well. The support is there but the bureaucratic alignment between that support, what the services say and how the money is earmarked has not yet quite become aligned the way we would like it to be in relation to this.

Senator ADAMS—I would like to talk about the rehabilitation of people coming out of residential care back into the community. Do you have any role in that as a foundation?

Mr Calleja—Yes, we do. We have a number of services in the metropolitan area and in Bunbury and Busselton where people come into our service. We have a strong belief, as I said earlier, about hope and recovery being a process. Fundamental to that is relationship building based on what the person’s view of their illness and recovery is—in other words, where they want to go and how they want to achieve that—and always reinforcing a belief that they can recover. We believe we have a very high level of recovery through our services. Many mainstream accommodation services maintain people in their illness. They do not deliberately intend to maintain people, but because they have no expectation necessarily that a person can recover they will not talk to them or work with them in a way that actually builds on their skill or their confidence. So we have a holistic approach.

Ms Mahboub—Richmond Fellowship has led the way in terms of training workers in this. We have actually changed the whole structure of working with people such that we have recovery workers now and recovery support workers. So the whole program from day one in the accommodation services, or even if it is a community service, is structured around not just rehabilitation but taking the person to that next step of being able to believe they can have a meaningful life of their own choosing.

Senator ADAMS—So they have a case manager. They are actually supported by an individual.

Ms Mahboub—If they are living in one of the Richmond residences they will have a case manager who belongs to the hospital system, a recovery worker who is their worker, recovery support workers to support them to learn a range of things that they need in order to get back to what they want to do and access to other supports in the community or within Richmond Fellowship. For example, recently Richmond Fellowship brought Ron Coleman to Perth to do some more training for the whole sector, and in addition to that they made him available to talk to people from the residence. One of the people, who was an ex-resident of Richmond Fellowship but still getting supported in some way, came to that conversation. He was a young person who I have worked with in the past who has had a range of very serious symptoms, including a lot of facial and body tics. Ron said that he had completely gotten over that. He was now living in the community. He had actually invited Ron to an outing rather than the other way around. Ron could see, in the time that he was going backwards and forwards, that he was able to give him support and support the workers of Richmond Fellowship to deliver—and they get to have access to a high-profile, internationally renowned person with a recovery experience of their own. So it is a specialist type of work that they get at Richmond, I would suggest.

Senator ADAMS—I am thinking back to the public system, to Shenton Park and its locked ward with people with head injuries and issues that have perhaps predisposed them to a mental illness. How would someone from there be referred to you? How would they get into your system?

Mr Calleja—In a couple of our residential settings we have been approached by Graylands to take on people who have both a head injury and a mental illness. Because of the strong disability component, the dual diagnosis, we usually get additional funding from the Disability Services Commission. That then enables us to employ what we would call a personal care assistant, someone who is there for very practical purposes. With that, on top of the more recovery oriented work, we are seeing the same results, in the sense that a person’s behaviours can be changed and modified in light of the support that they are given. A lot of it is strong psychosocial support, which is the basis of all of the interventions of Richmond Fellowship and non-government mental health agencies. So, even in the situations where there is a brain injury or something like that, it does not mean that recovery is not possible. It just means that there might be other ways that one has to work.

There is also a simple issue around language, too. When I first went to Richmond Fellowship five years ago as CEO, all of our staff were called rehabilitation workers or rehabilitation support workers. Just the simple act of changing the names to recovery workers is a powerful image and message.

Ms Mahboub—In terms of people with high-level needs, which you are asking about, one of the services of Richmond, the Kelmscott service, is part of the community options program that they have been trying to get off the ground for over 10 years. The last group of people in the Graylands psychiatric system were considered to have such high-level needs that they did not really know how to deinstitutionalise them, and a number of those people are now living at Kelmscott.

I was visiting Richmond the other day and a lady came in who was selling jewellery. I was talking to her about the jewellery and I did not realise she was one of the people from Kelmscott. She has got into this little business of making jewellery and selling things. I did not even realise that she was one of the residents from there. So it is having that hope and expectation, like Joe said, that supports people to move beyond where they think they can move.

Senator ADAMS—How did you get yourself to where you are now?

Ms Mahboub—I was really lucky. When I was 16 or so, the first time I visited a doctor, experiencing what these days would commonly be called a psychotic episode, my doctor said, 'Don't worry. She's just having a nervous breakdown. She'll get better. She just needs old-fashioned chicken soup, a break from the stress in her life as a young teenager and family support.' And that is what I got. So I had the language of recovery from day one. I never bought into the revolving door syndrome, thank goodness. It could have happened and it so easily does happen to so many young people today. Their experience is framed as: 'You've got X diagnosis. Therefore, you might as well give up your hopes and dreams of ever working. You will always experience this and you have to be on heavy duty medication for the rest of your life.' Having that experience of hope and belief, I did recover. Sure, I have had to do it several times throughout my life, but I know it. I know that you can recover, so I do not doubt it. So that is what I share when I work with people in the training. That is what we share with the workers who come to Richmond. In connecting with many, many people who have lived the experience of recovery, you see that it works.

Senator ADAMS—You are very fortunate.

Ms Mahboub—Yes.

Senator ADAMS—I am just thinking about some of the people I have come across over the years. If only at the start they could have had that sort of support.

Ms Mahboub—We see people coming into the Voices group who say, 'Hi. I'm Bill. I'm schizophrenic.' After a while, they walk in and say, 'Hi. I'm Bill. I'm a voice hearer!' Their whole identity changes. Imagine going to a party and introducing yourself as schizophrenic. But if you say you are a voice hearer you prompt people to lean forward and start to ask more questions. You can change your identity in the world.

Senator FURNER—Your information booklet identifies that possibly four per cent of the population experiences hearing voices. How was that figure reached?

Ms Mahboub—A range of studies have been done over the years. I cannot remember the date, but you will see the reference in there to Tien et al. They were one of the main leaders there. The statistic ranges—depending on, as you would know from the research, the questions asked and the particular group—from two per cent to 10 per cent. One study even showed that it was 35 per cent of the particular group that they asked, which was a group of students. Maybe it was around exam time, but they were all having that kind of experience. It has been replicated again and again, so they have come to this figure of between two and four per cent. What they are talking about in that particular study is anybody who has had this kind of experience. What we do is work with people who have these experiences and are distressed by them. There are a number of high-profile people who might have the experience of hearing voices, but they are not necessarily distressed by them and therefore they are not diagnosed as mentally ill. A lot of people in the community live with these kinds of things. You hear of authors and painters who will say, 'I didn't write the book. It was given to me.' But what we are dealing with in the mental health sector is a subgroup of that group who are distressed by their experience or their lives are impacted in some way by the experience and then they are diagnosed.

When Professor Marius Romme first discovered this, he realised that, because there were a number of people living well in the community who were having this kind of experience, there was possibly something to share. If you can learn to cope with the voices and you are living well in the community and you are not diagnosed as mentally ill, then perhaps people who are diagnosed with a mental illness and are incredibly distressed by the experience can learn to have control and mastery over it. That is how it really started.

Senator FURNER—So most of your clients would be dealing with negative voices. Would that be the issue?

Ms Mahboub—For the most part. Sometimes people will have some positive experiences of voices as well. A large part of this work is about helping people work on the relationships between voices. For example, someone might say, ‘I have a really negative voice and it’s right here, but I have a really positive voice and it’s out there.’ We will help to try and bring that one in. A very high percentage of people with this diagnosis will identify that the voices started after some kind of trauma or some event in their life that they perceived as traumatic. They will often find that the voices are related to that experience. Getting support for those experiences, for a lot of people, is incredibly helpful.

CHAIR—I have a couple of questions. I would like to go to the issue of whether more clinicians are involved in the process now that you have it up and running and it is showing positive responses. Are there more clinicians engaging with the process now?

Ms Mahboub—There is an increasing number coming to the training, because of the interest. Word of mouth is bringing people who are interested in coming and learning more. My understanding of some of the people who have done that training is that they have found that they have more of a toolkit. They are more able to talk to people who they are working with. It might seem strange, but a lot of clinicians have said that they have not really known what to do with psychosis or hearing voices. But there is a parallel process going on as well. In Australia we are recognising that this is the way forward, so there is some training and conversations and support for clinicians to learn more, on the one hand. It is possibly not enough, but it is happening and it is happening from within academia and across the board. For a little while there, some people were a little bit frustrated. I know of one clinician who went to the UK for a number of years to consolidate and work in a system that is much more accepting of different ways of approaching this sort of topic. I believe she has now come back. That happened a little bit too.

CHAIR—Do you get clinicians referring people to you, suggesting that this may be a way for people to receive help and recover?

Ms Mahboub—Yes, I think so. Because there is not a natural referral system it is up to the individual, if they want to come to a Voices group—

CHAIR—So it is a case of suggesting or recommending.

Ms Mahboub—Yes. Other organisations, like the June O’Connor Centre, run Voices groups as well, so they would probably be able to answer that question in more detail. It is not as much as we would like. We would really like to get the message out there and assist some of the clinicians who are fearful and who have not had an opportunity to really engage with what we are talking about.

Mr Calleja—We think that there are probably a lot more clinicians out there who would like to refer to our groups but the system will not allow it. I think that is part of the issue as well.

Senator ADAMS—I was wondering how the interface was between the public system and the help that your groups can provide. How does a person get from A to B if their clinician is not able to refer or does not know about you?

Ms Mahboub—And I think, too, with better funding we could get the message out there. We could set up more groups and we could train more facilitators and co-facilitators. The co-facilitator is usually a voice hearer, and hopefully in the end they will become the facilitator. The Hearing Voices Network has to do both. We have to do the training and sharing of information but also try and support other organisations to run groups. In the future, all being well, we will be able to answer that question better because we will have more groups and more messages out there—and then more referrals.

Senator ADAMS—I come from a very small rural community and that is why I was trying to see how you are expanding the service, especially with WA having so many small rural communities. Being in Perth, I am just using Shenton Park as an example. When people are discharged and they then go back, possibly, to the area where the problem started or where they associate the voices once more, how do they get help and who do they go to?

Ms Mahboub—Part of the role of the network is to support someone in that rural community to start a voices group. In New South Wales, for example, the dad of a voice hearer who was having major troubles started the Hearing Voices Network in New South Wales. On ABC Radio National there is a podcast where you can listen to him and his daughter speaking on that. In Dundee, Scotland, the Hearing Voices Network centre was started by a carer. The role of the network is not always to run the groups. Ideally, if we could have funding to go to rural groups it would help. A voices group can start with a cup of tea and two voice hearers. That is a voices group. So it is about supporting those individuals to hold that space and helping them to hire a hall or whatever.

CHAIR—How much does it cost to run at the moment? Is there a cost for participants?

Ms Mahboub—There is not a cost for participants.

CHAIR—How much do you need to run the network?

Mr Calleja—We would probably need around $120,000 to maintain it, and that would then enable us to be a support to agencies and regional communities. We do a lot of work via the telephone. Marlene, who could not be here today, is forever on the phone. Lyn used to be forever on the phone. You could always tell when you could go into Lyn's office: when the light on the phone was off! It is about facilitation as well as running the groups.

Ms Mahboub—And it is building relationships. We managed to develop a good relationship with an Esperance group, BOICO. There was a coordinator there who was incredible and who supported that. We had voice hearers come up from Esperance who found funding to do so. The role of Hearing Voices Network Australia is to spread the message far and wide, and also to build over to the east and connect the existing networks, but there has been no funding yet for that.

Mr Calleja—But in spite of that we have been able to support the development of a network in Tasmania. We supported Victoria. We have supported New South Wales. We have had a couple of attempts in Queensland. In South Australia I think there was a bit of contact. That is our function, really: to help grow it in other places. We are growing it in regional centres such as Bunbury, Busselton and Esperance, and we provided support in Albany.

CHAIR—Thank you. I have taken us over time, but we find this information so useful that we normally do go a bit over time. We really appreciate your time in coming and sharing your information with us.

Ms Mahboub—We appreciate it.

Proceedings suspended from 3.19 pm to 3.32 pm

KICKETT, Mr Darryl, Coordinator, Nyungar Health Council Limited

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

Mr Kickett—I understand the terms of reference for this are related to the broader community in relation to suicide, and I am here to talk about Aboriginal suicides particularly in the southern part of this state. We have had spates of suicides happening. There were a number of suicides in the Narrogin and a number of younger people suicided in Albany. Most of the Narrogin suicides happened in 2008. There was a spate of them in the first six months when around four suicides happened within six months. But, for the record, that year we experienced about eight suicides.

Senator MOORE—Were all of them males?

Mr Kickett—All of them were males. In Albany they were females around the ages of 14 or 15 years old and I think they happened in 2009. I was with the Aboriginal Health Council of Western Australia as the chief executive officer for 2008-09 and it was in that capacity that I was called into Narrogin and Albany to see what we could do. We went to the state government for funding and were unsuccessful at first. We then went to Oxfam Australia and they provided around $50,000 to do work in Narrogin in 2008. I think we received that funding in June 2008.

We were able to employ a psychologist named Darryl Henry to do work with the families. He went and initially held a meeting with at least four families who had lost either sons or grandsons in 2008. He explained to them what was happening in relation to suicides and made them more aware of what was happening. I think they really appreciated that. They asked him to go back, so he went back and provided counselling support to them and introduced a model that he had developed around suicide prevention. He invited strong members of the families to come together to work with him. He was able to pay them for three or four hours per week to work with him to strengthen the families from the inside. So he worked with those families and in fact the people that he trained actually got jobs later on.

I think probably due to that work the suicides dropped off. We had one suicide after that, but that happened in Perth. The parents lived in Narrogin but the young man was living in Perth. There were a number of people at risk and he was able to pull together the family members to form a team to provide a 24-hour watch for those at risk and to work with the police. I think the police really appreciated that. Then in late 2008 a request was made from the community members because they had formed a reference group and they had also been talking to a local committee made up of government department representatives in Narrogin called the intra-agency group. So they all got together and Kim Hames was invited up to Narrogin. He went along with the new mental health minister for the state, Minister Jacobs, and those ministers were asked to establish a men’s crisis centre in Narrogin.

What the department did, through the director-general, Peter Flett—he is no longer there now; Kim Snowball has taken over—was agree to provide some funding for the fitting-out of a house that was made available by the state Housing and Works Department for a crisis centre. I think

Peter made available $36,000 for it to be fitted out. But there was no real understanding by the department of what was needed, so nothing happened. At some point, because of the shortage of housing in Narrogin, the community agreed that it be handed back to be used for accommodation for a family in crisis. So nothing further has happened in relation to a men’s crisis centre.

Oxfam have since extended their funding for 2009 and through to June this year. They have also asked Darryl Henry to support Albany, so he has gone to Albany and met with the women and others down there and they are inviting him back to run some counselling sessions. What he has been doing is nothing new. The kind of model he has introduced to strengthen families from the inside has been a part of discussions at the national level. It is about taking a social and emotional wellbeing approach; a community development form is what I call it. It is empowering the people to take control over their own situations, and through that process the families have become strengthened. They are still facing a huge battle in relation to some of the underlying symptoms, if you like, that come with these suicide attempts. The use of drugs and alcohol, for example, is rife in Narrogin and in other towns in the south as well. Some members of families are involved in carrying and delivering drugs to Narrogin, and I imagine that would be the case in Albany.

The effect of drugs has been significant in suicides, I understand from a report from one of the mothers. That was in a newspaper report. She believed the use of ice was a factor in her son’s death, that it enabled her son who suicided to be strong enough to do it. So working with families and encouraging them to work with their kids and with the service providers so that they access the services that are there in a much more meaningful way is extremely important. The strong family members have been doing that. They have been shepherding the people who have problems into housing, for example, and into the mental health services in the town if they need that, and even to the hospital in a crisis situation. I know that the hospital emergency department have been doing a wonderful job with Aboriginal clients who go in there. There is a wonderful nurse who runs the emergency department there who has been very helpful. They have had some problems with being in the hospital, with some differences with a nurse in the mental care area, but they have been able to sort that out, I think.

I will give you an example. One of the people was put into hospital because he was suicidal. There was a family feud happening in the town and the nurse went up to the person who had tried to commit suicide and said to him, ‘So-and-so is a lovely person, isn’t she? I really, really like her.’ She was part of the opposing family. That really upset him, so he walked out of the hospital. So there is that kind of thing happening.

I think the mental health services are only just being reorganised, becoming more separate from the state health and country health services. I think that is a good thing. They have been focusing mainly on the extreme end of the spectrum. If you look at those who need mental health services, they can be measured from seven to 10, with 10 being the worst case. People in the one to six range remain in the social and emotional wellbeing area, where counselling becomes extremely important.

We know that Aboriginal people in Narrogin are very reluctant to go into an office based service. They would prefer that the workers came out to see them in their homes, but that is not a policy of the state mental health services at the moment. They had a really good worker within the department of health up there, an Aboriginal guy named Wayne Coles, who was excellent.

He was called on on weekends and out of hours to assist people to go to hospital or to get support. About two months ago he broke down and now we have lost him. He has had to pull out. There is a lack of training. There is a lack of a good, solid Aboriginal employment strategy within state health and mental health services. It has not really happened.

We are now moving towards the idea that if the state government are reluctant to maintain an Aboriginal specific service in those towns for suicide prevention then we need to try another tack. So we went to the Menzies School of Health Research in Darwin and spoke to them about what possibilities existed. They were doing a mental health project, in partnership with Yothu Yindi, from an Australian research grant. That involved placing families at the centre of the research project and working through issues, and setting up partnerships with state and Commonwealth agencies, local government and other service providers in the Arnhem Land area. Out of it came clear direction for the families on how to deal with suicide prevention. Out of it came proposals for projects for funding, based on evidence that the research project brought out. They are keen to work with us in Narrogin and Albany, and other places perhaps, to put up a research proposal to the Australian Research Council to do the same for those towns. In that way, we might be able to convince the government what the right direction ought to be. Our letters, words and approaches have not really been successful because of this unwritten policy of mainstreaming the services in the south.

They were very reluctant to talk to us about Aboriginal medical services being set up or other Aboriginal-specific health services. That is why we grew the Nyungar Health Council, which we will now start to develop our plans for. We have provided three positions on the board for it and we are lucky that Fiona Stanley has agreed to sit on our board as a board member, along with perhaps a couple of other experts. We have the KEEDAC organisation in Narrogin, which is a CDEP organisation. It covers Narrogin and Northam in the wheat belt area. The Southern Aboriginal Corporation is a member, the South West Aboriginal Medical Service is a member and Derbarl Yerrigan in Perth is a member. We are talking about those organisations proceeding to set up effective primary healthcare centres within those four zones of the south so that we can have a go at Aboriginal control and leadership around health to negotiate partnerships with government and GP divisions and other service providers and try to turn these things around—to close the gap in life expectancy. We are looking at working with Fiona on a child and maternal health strategy for the Nyungar Health Council and for the south.

We want to look at establishing a brokerage service for Aboriginal people in the south so that there is brokerage support to shepherd people into accessing GP services and other service providers. We are going to work on proposals for that through the Nyungar Health Council. We have got to work out how we are going to set up these primary healthcare centres in Albany to cover the area from Albany to Katanning and then in Narrogin to cover the area from Narrogin to Northam out to Merredin. Derbarl Yerrigan and SWAMS are being very supportive. We think that in this way we can give great assistance and contribution to the government efforts to close the gap in life expectancy as well. It starts with these important priority areas like child and maternal health and mental health or suicide prevention. The statistics to date from the state health reports show that there are growing numbers of hospitalisations for mental health issues. Mental health is becoming more of a serious problem for Aboriginal people down south. I will leave it there.

Senator ADAMS—Thank you very much for your introduction. I am from Kojaneerup, so I am certainly very aware of the areas that you are talking about. How is the Nyungar Health Council funded?

Mr Kickett—We do not have any funds at the moment. We are putting together a proposal for funding.

Senator ADAMS—Are you the acting executive officer or the coordinator?

Mr Kickett—Just the coordinator.

Senator ADAMS—So you are applying to the state government, the federal government—who are you applying to for funding?

Mr Kickett—We would apply to both state and federal to see what possibilities there are.

Senator ADAMS—How far have you got? You have talked about who might be on the board but have you got your constitution set up? How far have you got in that respect?

Mr Kickett—We have been incorporated just recently.

Senator ADAMS—That is what was worrying me—whether you were an incorporated body or just where you were at. At least you have that structure sorted. With Aboriginal medical health services, are you getting any help from Bunbury at the moment?

Mr Kickett—Yes, the South West Aboriginal Medical Service provides support.

Senator ADAMS—They are actually helping in Narrogin?

Mr Kickett—They actually paid for the incorporation to happen.

CHAIR—SWAMS do not normally cover Narrogin, do they? They are extending their boundaries to help them, aren’t they?

Mr Kickett—They are in the south-west—Bunbury to the Collie area.

Senator ADAMS—So do you eventually see an Aboriginal health service being set up in the wheat belt for the Great Southern? It would not be coming out of your Nyungar Health Council. Would that be one of your aims?

Mr Kickett—We have had requests at meetings that we have attended. There was a huge community meeting. There was a medical service set up and they told the state governments representatives who were there. We have had requests from the Narrogin northern people as well. We have also had requests from the Kwinana-Rockingham area, the Mandurah area and the Midland area in relation to their own medical service. Durbell provides some coverage of those places; they have clients there as well, and they are looking at restructuring at the moment to better service those clients in those outlying areas. They are currently centrally based in Perth, Maddington and Mirrabooka, with clinics in those three areas.

Senator ADAMS—Do they have enough GPs to spread around?

Mr Kickett—They have just set up a street doctor program. That runs to Cullacabardee and out to Midland. We hope that will also run down to Kwinana for at least a one- or two-day clinic each week or fortnight.

Senator ADAMS—So that is for Aboriginal people. What about your people going to the street doctor program in Fremantle? Do they patronise that? It is probably based on that model, and that is very successful.

Mr Kickett—Yes, they have a very successful street doctor program.

Senator ADAMS—To come back to Narrogin, will your health council have any Narrogin city council involvement to help support you?

Mr Kickett—The Narrogin town council started setting up a reconciliation program in Narrogin.

Senator ADAMS—You were talking before about the house having to go back to being a family crisis place. Would the shire be able to provide facilities for your health council to get itself organised?

Mr Kickett—There is very little accommodation in Narrogin and it is all fairly tightly taken up, so it is very hard to get any accommodation. We also have the Southern Aboriginal Corporation, who own houses in Narrogin. Maybe we can have some discussions with them about providing a house, but I really think the state government needs to take some responsibility. I know that police have a lot of problems with people with mental illness or suicidal tendencies. All they do is put them in a cell. That is not very nice for people with those thoughts. Police are also part of the push in Narrogin to get a place for that to happen. I think the department of housing and work say that if proper funding is provided they would make another house available if something came up. The thought of the director-general at the time was that you could get a couple of old people to caretake the house at night or something when people were having problems. Our argument was that you need trained people in there to do that; otherwise, you are putting these old people in danger. Some of these places we have looked at have costings for running and staffing of around $400,000 if you are going to be serious about it. Otherwise it just will not work.

Senator ADAMS—Will the Nyungar Health Council have its main office here in Perth or will it be situated down in the middle of either the wheat belt or the Great Southern so that you have a presence in the area that is the problem?

Mr Kickett—The registered head office is in Bunbury. The Derbarl Yerrigan Medical Service in East Perth has made available some office space, so we work there as well. We work with the Southern Aboriginal Cooperation and KEEDAC at the Katanning Education and Training Organisation in Narrogin. They have property in Northam and in Narrogin. They own their own buildings and they have agreed to work with us to set up primary healthcare centres in those places so that we actually manage and govern Aboriginal health across Nyungar country through a Nyungar structure.

Senator ADAMS—That was the reason I was asking about the shire or the council involvement just to ensure that you were going to be centred in the particular areas where you should be. What about Katanning? Can we move down a wee bit into the Great Southern. What is your plan for Katanning?

Mr Kickett—They have a site office in Katanning. It will take some further planning and development with both the Southern Aboriginal Corporation and KEEDAC in Narrogin to develop plans for how those things will be set up—what office space they will need, what staffing they will need—and then putting that together into a proposal for funding to go to the Commonwealth and state governments.

Senator ADAMS—Are you all right for office space in Albany?

Mr Kickett—Albany has a site office down there, so they will be doing the same thing.

Senator ADAMS—So you really have a network partnership already there which will help a lot to get this off the ground?

Mr Kickett—Yes, they are very excited about setting this up. We know there have been so many funerals. Funerals from suicides have just added to the grief and trauma, because you do not expect these people to die so suddenly. It has been so difficult with the waves of trauma and grief coming out of the early deaths not just from suicides but also from other illnesses. I think the last four deaths were at extremely young ages.

Senator ADAMS—What about the high school in Narrogin? How are you coping with that at the moment?

Mr Kickett—The high school has not managed very well the issues around suicide and the impact it is having on the Aboriginal students at the Narrogin High School. There has been fighting—a teacher fighting a student and there have been brawls. It seems that Aboriginal people in Narrogin do not have a voice at the high school and have no influence. A new principal is now there who is trying to do something, but he will need a lot of help.

Senator ADAMS—My information, from talking to different people in the area, is that Narrogin as a community is coming together to try to do something rather than it being a case of perhaps nobody really being worried because it was a ‘them and us’ thing. It has been a very traumatic period, but I think it is settling down and people are really trying to come together to help in different directions.

Mr Kickett—I think what has happened is that there has been a breakdown between the two feuding families, the two groups, in Narrogin. One of the families is not going to any of the meetings that have been set up by government—the interagency group meetings, for example. They have decided to stay away because they believe that the other family is promoting the violence—the attacks on houses in the middle of the night, the continual harassment. And we know that when young people drink alcohol or are on drugs they carry that fight on, on both sides. So the remedy has not yet been reached in Narrogin.

Senator ADAMS—But there is a lot more support from all the different agencies and people around the community to try to solve the problem. Would you say that, compared with the way it was before?

Mr Kickett—Because I do not live in Narrogin I really cannot see what those people you are talking about are doing.

Senator ADAMS—Are you getting any reports back, though?

Mr Kickett—There is some goodwill from some people. You have Heidi Astbury, who is wonderful. She has helped set up a TAFE course for those high school students who were too afraid to go to high school. So they are running a TAFE course for them, separate from everything else. The churches up there are wonderful. The ladies have been doing things like catering for funerals where people have suicided. The police have been doing the best that they can in the circumstances. There are still accusations of racism in the police and unnecessary harassment of those people who are at risk by some of the families. We heard that last week. I am not sure whether you know but Michael Gooda, the new commissioner—

CHAIR—Yes, he went down—last week, wasn't it?

Mr Kickett—Yes, he went down to Narrogin last week and I attended that meeting. So there are a lot of these complaints coming out of there. The new race relations commissioner and disabilities commissioner were there. But there is never any effective long-term strategic approach to these things in Narrogin. There are always these short-term, knee-jerk responses.

Senator FURNER—You said that the use of drugs is rife in the area, and then you went on to talk about ice. Are there any other types of drugs that are of major concern?

Mr Kickett—I know that injecting drugs, like amphetamines, are there. A couple of my nephews are on it. They have difficulty getting off it because of the urges. Darryl Henry has been trying to counsel them—teach them how to breath, and that kind of thing, to try and stay off it. We are happy that one of the boys we were talking to actually gave the drugs up. He has been off them for four months now and is looking for a job in the mines. So we are very proud of him.

Senator FURNER—It is indicated that there are families involved in the supply?

Mr Kickett—Yes, I know there are families involved in the supply. I have been told this by family members themselves.

Senator FURNER—Has that been reported to the police to follow up for investigation?

Mr Kickett—Yes. My brother Basil Kickett lives there. He reports to the police regularly of who is supplying drugs, but no action has been taken. The police say to him that they want to catch the big fish.

Senator FURNER—Can you just elaborate more on the position of strengthening the family from inside? That has certainly been an initiative that we in this committee have seen in relation to other types of issues, particularly out in Central Australia with petrol sniffing, where things are driven from the inside in the communities by the families and there have been some positive changes where that has occurred. Can you elaborate on that concept and how that should happen?

Mr Kickett—The idea is not new. It is really an old community development idea. I taught community development at Curtin university as a lecturer. It is about empowering people to fix up their own problems. Giving family members that kind of support by someone who could be a facilitator is very effective, because they start to see other ways of doing things. Through that support, they are able to talk these things through and come up with new ideas and strategies—problem-solving methods that are going to work. That has been a fairly effective.

One of the leaders down there, Priscilla Kickett—she is my niece—lost her husband through suicide and she has been working very closely with others. Two family members who experienced suicides during 2008 were involved. One was a guy called Jock Abraham. He has been working with the South West Aboriginal Medical Service in Narrogin partnering with a social worker to work with the families to deal with social problems.

Darryl Henry has been working with families through a guy called Rocky Bolton to work on the suicides in that family. That has been very effective. It is about planning what to do in relation to suicide prevention, understanding what suicide is, why it happens, what the triggers are and how you can prevent suicide.

There has also been money given to a group in Mandurah—the chamber of commerce, I think—to provide suicide prevention training in Narrogin. That is a kind of hit-and-miss thing, because it is content driven. You try to learn from content and the instructions that the trainer gives you. But the way that Darryl Henry does it is on the job, getting involved straightaway with understanding what suicides are and how they can be prevented.

It is setting up structures within families that work, like the 24-hour watch thing, about how to shepherd people into hospitals or into mental health services or to the police if they need to get support. It is about having access to Darryl Henry by telephone on a 24-hour basis to provide advice, support and follow-up. A lot of the people who have tried to commit suicide have actually been in phone contact with Darryl regularly.

CHAIR—So Darryl is continuing to be funded by Oxfam?

Mr Kickett—Yes. He can only visit Narrogin one week out of every month.

CHAIR—While I am on funding for people that are working in the community, I heard a rumour that Paul Sheridan from SWAMS had resigned or is not working for them anymore. Is that right? Will that position be replaced?

Mr Kickett—Paul was a young fellow. He had just recently become a social worker before he went to Narrogin. He was thrown in at the deep end, not having had any experience before he went to Narrogin. But he was very good and a lot of clients went to him around social problems. But he felt that he had to move on. They had trouble getting someone. We know that social workers and GPs only go to live in Perth and Bunbury. So he has left and I think they have got a consultant doing a couple of days a week in Narrogin.

CHAIR—They had trouble getting funding in the first place,

Mr Kickett—Yes.

CHAIR—And they have trouble getting staff. Do they still have the funding?

Mr Kickett—They have some funding, yes, until the end of June. I am not sure how they are going to go after that.

CHAIR—Do they still have only a man and not a woman—they did not have funding?

Mr Kickett—They have only a man, a part-time social worker, and they do not have a receptionist either.

CHAIR—So that situation is still the same?

Mr Kickett—Yes. Meanwhile, suicides have been happening elsewhere—in York, Northam and other places. There are a lot of suicides happening in Perth amongst young people. My nephew died last year because of suicide. He was 26 years old. It just goes on and on. There is no strategy in the southern area for the prevention of suicides. There is a state-wide mental health strategy—and I think $22 million of COAG funding has gone to that state strategy, but there is no funding available for Aboriginal-specific, Aboriginal community controlled suicide prevention.

Senator FURNER—We heard in Victoria from beyondblue about partnerships with business, particularly the construction industry—how they are trying to establish means for fixing this particular issue. Have there ever been any approaches to businesses in Western Australia—as an example, the mining industry—to see whether there are opportunities to assist in programs?

Mr Kickett—Employment programs, yes.

Senator FURNER—Just employment? There is nothing with regard to—

Mr Kickett—Boddington are going to have 200 Aboriginal workers at the Boddington mine, but I am not sure what is happening in the local business community in Narrogin. I see some workers employed at the local Coles shopping centre. The only information you get is from the 2006 census, but there is no drilldown into what employment is available, what jobs are available, and whether Aboriginal people can access those jobs in that area.

CHAIR—When I was in Albany last year there was a whole mob of people that had come off CDEP around Mount Barker. It was last year so it may have changed, but I am told that about 70 people had come off CDEP down there when it was canned. Do you have any information on that or any update on that?

Mr Kickett—I understand that at that time both Narrogin and Albany lost CDEP funding and had to apply with everyone else for funding for Newstart—or is it Jobstart?

CHAIR—There is Newstart and Work for the Dole.

Mr Kickett—Job services. KEEDAC have been very successful just recently. In fact, I helped them put together a proposal for the Personal Helpers and Mentors program from Jenny Macklin’s department, FaHCSIA—Indigenous affairs.

CHAIR—Community services.

Mr Kickett—Darryl Henry and his psychologist team helped KEEDAC put that together with support from the Southern Aboriginal Corporation and the Derbal Yerrigon Health Service in Perth, and they were successful and won the contract—$1.5 million over three years for five workers for the Personal Helpers and Mentors program in the Narrogin-Katanning area, so that is wonderful. KEEDAC are very excited about that. They have just got the contract and signed it and are now organising to set it up and recruit staff with Darryl Henry’s support. So that is a wonderful thing.

They were also successful in getting what I think is called the job ready program from FaHCSIA. They won that project to get people ready for jobs, so that is a good thing. I am not sure what Southern Aboriginal Corporation is doing but they own a number of houses—at least 70—throughout the south that they rent out to Aboriginal people.

CHAIR—We have run over time a bit but there were some key issues that we wanted to chase up. We had been following up with the council and they said, ‘Ask you,’ because you have been largely running the work in Narrogin. They said to ask you, and we did.

Mr Kickett—One thing I want to say is: we need to do more in the old missions. There is Roelands. There is Marribank near Katanning and Mogumber up near Moora. They are sitting there doing nothing.

Senator ADAMS—So what do you suggest?

Mr Kickett—I think we need to get some healing programs happening through those missions.

CHAIR—Do you know if anyone has applied for funding through the healing foundation?

Mr Kickett—I do not know if they have got funding out yet, have they?

CHAIR—They have set up the board—they had their issues with the board and the CEO.

Senator MOORE—They put something out—expressions of interest.

CHAIR—It may have only just gone out, so there may be some funding there.

Mr Kickett—I will have a look.

CHAIR—Without going into a whole lot of other issues, since that funding pot is there, it seems to me that that is the pot that might be able to fit the bill there.

Mr Kickett—I will give my friend Lowitja a ring—Aunty Lowitja.

CHAIR—Thank you very much. Your time and your evidence is very much appreciated.

Mr Kickett—Thanks for having me. I loved coming.

[4.23 pm]

DOUST, Mrs Margaret, Volunteer Peer Supporter, Active Response Bereavement OutReach

HILLMAN, Ms Sharon Dianne, Manager, Active Response Bereavement OutReach

HUDSON, Ms Josephine Frances Elizabeth, Chairperson, Expert Reference Group, Active Response Bereavement OutReach

CHAIR—Welcome. I understand you have all had information on parliamentary privilege and the protection of witnesses and evidence. I invite one or each of you, depending how you want to start, to make an opening statement and then we will ask you some questions.

Ms Hillman—First of all, thank you for giving us the opportunity to speak here today. I think it is a very important inquiry and I am looking forward to seeing the outcomes from it.

As I said, I am the manager with ARBOR. I have been involved in suicide bereavement in WA for the last 10 years and suicide prevention for the last 12 years. Josephine Hudson is our chair. She is also a grief and loss specialist. She is here to answer any queries and provide information on grief and loss specific to suicide bereavement. As Mark said, she is one of our inaugural peer supporters. She has been with us since day one when we started services. She is here to talk about here experiences and her involvement with ARBOR.

What I want to do is to briefly give you the background on suicide bereavement in WA. I know that you would have had a lot of submissions talking about the statistics and the particular issues and difficulties involved with being bereaved by suicide and working through that loss, so I really do not want to go into that here. I more want to give you a bit of background on what has been happening in WA over the last 10 to 12 years that I have been involved.

The first point is that pretty much historically in WA there has been very little done. Things started happening five or six years ago. To start off with, we recognised this gap in the late 1990s. Bereaved people were not getting support. We were talking about youth suicide prevention and other prevention strategies, but we were not talking about people at risk because of their losses. We conducted a pretty small study—a needs assessment—with people bereaved by suicide. It was really just a fishing expedition at that point in time. But a couple of key things came out of that, and you will see these things in the literature over and over again. People did not know where to look for support. They did not know who to approach or where to get help, and they certainly were in no state to go out searching for it. They wanted direct contact from a support service. I remember people saying, ‘I want someone to knock on my door and say, “I’m so sorry; how can I help?”‘ They also wanted the provision of written material—things that they could hold on to and look at when they wanted emotional and other support. They also wanted the opportunity to talk to others who had been through the same experience.

At this point, in early 2000, we formed the bereavement support working group of what was then the Youth Suicide Advisory Council. It is now the Ministerial Council for Suicide

Prevention, which you probably know about. It is going through a new incarnation as we speak. Within that, we sought funding to develop an information support pack, which was one of the recommendations, for people bereaved by suicide. This is a resource that we developed in conjunction with people bereaved by suicide. We had a reference group of about a dozen folks who had come out the other side, I guess. They really influenced what the pack looked like, what was in it, how it was disseminated and the like. I have copies of it floating it around. The very first WA one came out in 2001. It was distributed through WA.

The key thing with it was the dissemination process. It was what we term an active process. It was not a resource that was developed and then sat in an office waiting for people to find it; it was actually distributed. Since that point in time it has been distributed through the coroner’s office, because that is the one place where every death by suicide is recorded and a family member is on their books as being notified. What happens is that they get a copy of this pack. Either it is sent out after a phone call and a discussion or it is posted out with a letter.

In 2003, it went national. I have a copy here. It was developed by what was then Community Life, which was a national initiative. Essentially, it was exactly the same material. It was distributed through coroners’ offices as well, so again there was that active dissemination process. It was not distributed in New South Wales, because they had a resource that they used, and it was not distributed in Tasmania because, at the time that this was funded to go national, Tasmania was funded to develop their own pack. We updated the pact in a second national print, the third print all together, in 2007. That is the version that is just running out at this point in time. It is again distributed through coroners’ offices in that active way.

A fourth version came out last month. I briefly looked at some transcripts and saw that there was a bit of contention about who knew about it and who had heard about it. It is essentially the same document. It has a different format and there were a couple of minor changes. The main difference with this one is that it will not be disseminated through an active process. It sits in an office in a national distribution centre in Canberra or Sydney and people have to know that it exists and call to get themselves a copy sent out.

CHAIR—Why is that?

Ms Hillman—That is a very good question. We were not involved in the development of this last version. It went out to tender. I do not know a lot about it, but the people who got the tender were toing and froing with DOHA a lot about it and what the mandate was. There was a lot of confusion as well. We developed it as a resource for bereaved people, not for professionals. Professionals wanted to get their hands on it, because it had a wealth of information and helped them to work with bereaved people.

The talk when they were looking at this pack was that it was for professionals and all their consultation was with professionals not with bereaved people. I did have a couple of discussions reminding them that it actually was not a resource for professionals. Yes, they like it and they find it handy, but it was a resource for people who were bereaved, not for professionals. That is why it looks like this, with brochures that people could take out. It was not overwhelming. They could take out one piece of paper, read it and leave the rest aside. When we were developing it, I remember showing them all the different formats for what it could be, including a booklet, and the consensus was really that they did not want anything overwhelming, anything that looked like a book or anything that had too many words in it, and those kinds of things. I think that was probably one of the issues.

I did speak with Chris Killick-Moran from the suicide prevention area in DoHA. I asked him why there was not a dissemination strategy with this last one and what that dissemination strategy was going to be, if anything. He said that they had not talked about it and that they would. The next I heard was when I got an email saying, ‘This resource is available’, so I ordered some, and we use them with our clients. From there the bereavement support working group put in some funding to develop an active intervention model, and we sit here as that model, ARBOR. The funding was through the National Suicide Prevention Program, and ARBOR is an initiative between Curtin University and the Telethon Institute for Child Health Research. Our goals are to provide early information and support to reduce the risk of suicide and to raise awareness of the complexities of suicide bereavement amongst allied health professionals.

We have on our expert reference group people bereaved by suicide who inform the process of the model. We are largely based on the work of Frank Campbell, who I assume you would have heard about a number of times. He is based in the US and touted the active response model. He has a loss team that goes out pretty much immediately at the time of loss to families bereaved by suicide. Certainly that was something we wanted to do. We needed to recognise that the coronial system in the US is a medical system and the coronial system here is a legal system, so there were certain difficulties with going out immediately like that. We developed a direct referral relationship with the coroner’s office for every death by suicide. It takes a number of years for a finding to come down but, if it seems apparent that the death was likely to have been a suicide, the counsellors will ring the family. They will offer their condolences and their support and they will also let them know about us. If a family wants referral to u, that referral is made to us and then we contact the family directly.

CHAIR—Sorry, I am interrupting, I know, but I might as well ask while that is in my head.

Ms Hillman—That is all right.

CHAIR—What is the time frame?

Ms Hillman—That we contact families in?

Senator MOORE—For the whole referral process.

CHAIR—Yes.

Ms Hillman—The coroner’s office contacts within a day to two weeks, and once we get that referral we contact within 24 hours.

CHAIR—Then it could be two weeks before you are contacted.

Ms Hillman—It could be two weeks, yes. We have responded to families within days and we have supported people 11 years down the track. We certainly are set out to be an early intervention service. There have been some difficulties with that, certainly. For one, the counselling service in the coroner's office is understaffed and they have so much work to go through that sometimes it sits back before they can actually contact the family. But we are working on that. They have just got another counsellor on board, fortunately, so hopefully that will make a difference.

One of the things that makes ARBOR unique as a suicide postvention service within Australia is that direct relationship with the coroner's office. We are an active postvention model rather than a service that gets built and waits for people to find it. I think that is really important with this type of grief and loss. We are also a high-capacity service. We can respond to up to 6 new referrals a week and we average three home visits a week with families. So this kind of model suits larger areas like large towns and cities.

We also have peer support, which is unique to the services in Australia. These are people bereaved by suicide themselves who we train and support to support those newly bereaved, and they work hand in hand with our counsellors. It is a peer supporter and a counsellor who go out to families in their homes. We currently have a team of about 15 peer supporters working with us.

Our staff are full-time workers with ARBOR, so this is what they do day in and day out. They are grief and loss specialists. They are suicide sensitive. They all have postgraduate qualifications in counselling or the like.

The other thing that makes us unique is that we provide more than one-off support. We found from the evaluation of the initial pilot phase of ARBOR that people who just got a home visit were not doing too well six months down the track and actually could have done with more support. Those who got more support were still struggling through but were getting that support and reaching out more, so they were getting support that they needed. So not only do we do home visits; we offer ongoing counselling and we offer peer support. People can sit one on one with our peer supporters and talk about those mutual shared experiences.

We started up support groups in WA because WA, strangely enough, unlike any other state, just did not have support groups running. On and off you would have a self-help group which would last a little while and then disband, but there were no professionally facilitated support groups in WA. I have never been able to work out why. We worked hard to try and get other services to start them up and in the end we started them up ourselves.

We also do return-to-work support. That involves assisting our clients who move back into the workplace. We might go into a workplace and provide information for staff or for managers on how best to support this person coming back to work.

Our clients stay with us for an average of about three months at this stage. In that pilot period, we supported about 390 people bereaved by suicide.

I guess the major issue for us has been the continuity of funding. The funding is a three-year cycle, one would say, although it was delayed coming on, so it was about 2½, and the second round of funding was delayed also. The biggest issue was that our funding finished in May 2009—last year—but we did not get a new contract signed until October 2009, so for five months the staff and the service were in limbo and it was really destabilising. We had to wind down services, so people were not getting the support that they needed, because we did not know whether next week we were still going to be here or not. For our staff it was the same. They did not know whether next week they would have a job, so they really struggled through that period. I speak a little bit distantly from that because I was on maternity leave last year, so I was there just before it started and then I came back after it finished. But what we are focusing on now is rebuilding the service back up to capacity. The next funding round finishes in June 2011, so there is heightened anxiety, shall we say, around staff already about whether they are going to go through that again. I do not expect they will stay around to go through it again. I do not blame them.

The only other thing I want to touch on, really briefly, is the overall issues of suicide bereavement in WA. With the vast distances—we are a massive state—and the remoteness, it is really difficult to provide services throughout this state, and I think that needs to be recognised. I think too that on the west coast we feel quite isolated from the decisions that are made on the east coast. They are often made without consultation sometimes with the state office, let alone the community here, and that can be quite difficult. You find out about that after the fact.

I mentioned the underresourcing of the Coronial Counselling Service. Another issue is that there are only a few good grief and loss practitioners around. Grief and loss are a very hard area to work in. It takes a special kind of person. And then, when you add the complexity of suicide bereavement on top of that, you are really narrowing the opportunities to refer clients who might need it for longer term support. We do find that difficult. Your previous speaker would have much more knowledge and skills in this area than I do, but supporting Aboriginal people bereaved by suicide is another very complex area. Really a different approach is needed there.

We would like a more integrated approach between state and federal governments. We talk with one and we talk with the other but seldom do the two of them talk to each other and, if they do, it tends to be just rhetoric and there is no action at all. There is a need to further the evidence base on the impact of suicide and I think that an evaluation of these funded services needs to be more comprehensive. It needs to include details of methodological issues, because it is very difficult to evaluate well suicide bereavement services. There are ethical issues. You cannot have a control group. We are not going to offer some clients support and say to others, ‘No, sorry, we want to use you as comparison,’ and ‘It is not going to happen.’ When you are making comparison with general population samples you are really comparing oranges with apples. No-one actually says, ‘While we are not really comparing similar groups, here is what we found.’ They just say, ‘Here is what we found,’ and that is a shame.

There is a bit of competition between services, I think, and a bit of a ‘divide and conquer’ mentality. I would like to see services working closer together rather than having to compete to prove their worth and compete for funding, which is generally how it is. And of course raising awareness of suicide bereavement and help-seeking amongst the general community is really important and services like ours do not get funded to do that as much as they should to do the work that needs to be done. They are the issues I have. I will hand over to Marg who wants to talk a little bit in her capacity as a peer supporter with us.

Mrs Doust—Our daughter died about six a half years ago from suicide and what we went through as the result of her death was something that I did not want anyone else to go through. It was a strong feeling that I had very soon after her death that other people should not have to go through what we went through, and I guess that was the beginning of my wanting to do something about it.

All the time through my grief I really wanted to tell somebody about her death, to really talk about it, and I could not because it would give pain to anyone I talked to about it and then I would feel bad about making them feel bad. A lot of them could not deal with it anyway because they just did not have the tools and it was very hard on them. So I was constantly questioning myself about how I was handling her death: was I reacting normally; was I going crazy? I did believe for a long time that she would come home. I knew that she could not but I just could not stop the feeling that she was coming home. They were very strange feelings, thinking that you are going crazy. I felt guilty because I was able to go back to work and carry on like normal and not cry all the time—and I was thinking: is this normal? So I knew from the start that I wanted to do something to help stop this awful way people have to suffer.

About three years later the Ministerial Council for Suicide Prevention told me that there was going to be a project using volunteers and I went along to see the presentation by Frank Campbell. For the first time since her death I felt that I was really understood. The presentation was about everything that I would have needed if I could have used it at the beginning. Thankfully, I was included in the first intake of the peer support volunteers and my journey with others brought me a great deal of comfort and healing for myself as well as confidence in helping other people.

The training itself was another healing process for me as well. It was in a safe environment with all the support that I needed. Going out as a peer supporter, I feel that we bring hope to those that we visit. In the comfort of their own home we give them our individual attention, listening to them and answering their questions. We bring to them skills we have learned through our own life, turning our own grief experience into something useful and adding to that the training we gain from ARBOR. At the home visit we offer an open meeting with empathy and encouragement with the knowledge that we too have been in the same place. Knowing that we have survived and are there to help them gives them so much encouragement. The level of understanding we can offer gives them comfort. They can feel free to talk about things that they cannot often talk about with others.

The actual physical difference in people who have been visited by our counsellors and peer support volunteers is visible on the day you go to see them. When they open the door they are broken and sad and sometimes they are crying and terribly distressed. But after some time talking and realising that you really understand them, you can see the physical changes in their faces and their body language. It gives me a great sense of achievement. It is an incredible thing to be able to share those hard earned lessons with people who do not have the hindsight.

CHAIR—Ms Hudson, do you want to make an opening statement.

Ms Hudson—Very briefly, I see my role in coming to this inquiry as being able to provide some insight into bereavement counselling. When we talk about postvention—working with clients after a suicide has occurred in a family and working with a bereaved family—we are also talking about prevention in that process. The other aspect that I am able to speak to is around the area of research and having the knowledge to be able to train people to actually do the work of a counsellor in grief and loss.

Senator ADAMS—The practical aspect of your approach and the way you work is very interesting. This is what really worries me with referral: I do not think there is enough information out there for people at the moment about actually being referred. I come from a rural area, which makes it even harder. Do you speak on the phone to people? If someone from a rural area rings, are you there for them?

Ms Hillman—We do. We are funded to provide services in the Perth metropolitan area only, but we do not turn anyone away. Our goal, if we get someone from a rural and remote area, is to provide telephone support. They can come up and see us if they do not live too far away and we try to link them in with supports in their own area. That is probably the most difficult component of it. One of our counsellors at the moment has a client who is in the eastern states and they have telephone contacts regularly scheduled and provide support that way as well. That particular client moves between WA and the eastern states quite a bit, so it just worked out to be the best way to support her.

Senator ADAMS—Do you do any work with the Division of General Practice? What worries me is antidepressants being given for something that probably should have been worked through first. Often it is a quick fix and then things start to deteriorate.

Ms Hillman—That is a really good point. What we are developing in our training is trying to get practitioners to realise that the signs of depression are really similar to the signs of grief. What you need to do is actually work through the grief. Putting someone on antidepressants will generally just mask that grief and the grief work that needs to be done will not be done. Unfortunately, it is a misconception out there that people are depressed. Often people will go to their GPs and talk about how they are not sleeping, not coping and struggling but they will not actually disclose a loss. I think it puts GPs in quite a difficult position as well. So providing information around investigating further as to whether there are any triggers or losses involved is important.

Senator ADAMS—Do you work with health services as well here in the metro area?

Ms Hillman—We do a little. It is probably more referral relationships. We are just finalising a day of training for practitioners and one of our objectives in this funding period is to raise awareness amongst allied health professionals of the complexity of suicide bereavement. That certainly will involve more people from health services and the like.

Senator ADAMS—How is the training of your support people done? Do you get volunteers? How do you actually get people to come to take up those positions?

Ms Hillman—We recruit, basically. We use networks that we might already have. We advertise. There is a screening process that people go through. There is first a written application. It is very hard to judge via time where people are in their journey. We have a general ‘three years down the track’ rule, but three years down the track could be a microsecond for someone but much further along in the grief journey for someone else, so we also have an interview with potential peer supporters. They then have three days training as well. That again is part of the screening process. It is fairly rigorous, I would say.

We had some research conducted on our first rollout phase, the 18-month pilot, which looked at the effects on our peer supporters of being involved in this work. The measures were things like the Beck Depression Inventory, the anxiety inventory, complicated grief and the like. The research indicated that there were no negative benefits of being involved in this work as a peer supporter and that actually there were some positive benefits, as Marg did mention.

Senator ADAMS—I was going to ask you that, because it is really good to see, when you have gone through that experience, that you have the strength to come and help other people. There is no-one better able to really understand how a person feels than someone who has actually experienced something themselves. It is fine to read books and say, ‘I can do this or that,’ but if you have actually experienced something like that it is very good. That is the reason I was asking how you recruited your peer supporters.

Senator MOORE—Ms Hillman, I want to go back to the tender your group had for support for people who are bereaved. Did you actually put an application in for that tender?

Ms Hillman—We did in the first National Suicide Prevention Strategy funding round. It was in about 2006 I think.

Senator MOORE—Who got it?

Ms Hillman—The institute and Curtin. There was a bit of toing and froing because it could only be appointed to one body, so it went to Curtin. But the Curtin Centre for Developmental Health is a joint initiative between Curtin and the institute, and that is where it sits.

Senator MOORE—And the subsequent one?

Ms Hillman—It was not a tender process. There were discussions for six to nine months beforehand about whether or not there was going to be further funding. That was my understanding with all of the projects actually. There was not another open tender process. There were discussions and feedback on what worked—feedback from evaluations and state offices—and then decisions were made.

Senator MOORE—Were you involved in those discussions, seeing that your organisation had produced the previous support packages?

Ms Hillman—The ‘support packages’? Sorry; I thought you were talking about ARBOR.

Senator MOORE—You quite pointedly told us about the history—which is fine; we need to have that on record—but I am really interested in that tender.

Ms Hillman—We did tender for the very first pack. It was quite a small amount of money to R&D and produce it. I honestly do not recall about when it went out nationally. I think probably we had discussions about getting more in WA, and then Community Life came in and did that. We were not actually involved in that, apart from trying to get them not to have it red. We had very heated discussions about that, but that was their corporate colour. When it came back to the second national print we were approached to do it. I do not think it went out to tender. There was just a discussion with DoHA in Canberra.

Senator MOORE—Like a brand new contract?

Ms Hillman—Yes.

Senator MOORE—And then what happened?

Ms Hillman—The fourth one did go out to tender.

Senator MOORE—And did you tender?

Ms Hillman—We did not. I did not actually know that it was out. I was not notified and I did not see it in any papers or anything like that, so we did not know it was happening.

Senator MOORE—Okay. Who got it?

Ms Hillman—It was a consultancy firm in the eastern states. When I found out about it, I did have a couple of discussions with them. They were very good. I think they were having some issues with working out what the funding body wanted and what they were there to produce. My understanding, as I said, is that they only consulted with service providers, not with bereaved people. But I did point that out to them a couple of times.

Senator MOORE—The point was that they did not tell you they were putting the tender out and just left it for people to seek it out. That is how the tendering process works.

Ms Hillman—We would have been happy to have tendered for it, but we needed to know that it was available.

Senator MOORE—We will follow through on the details of that tender. I normally have the list of all the funded agencies with me, but it gets too heavy to lug around. My memory is that a lot of the money for support to families has gone to the Jesuit services in Melbourne. They seem to have been very successful in that round. There is also the crisis support centre, with whom we met the other day. Have you had anything to do with them? They are in the process of putting together a list of regional support. Have they spoken to you about that?

Ms Hillman—I have only been back in the role for two months, but there was nothing in the handover from the previous manager, no.

Senator MOORE—I will follow up specifically with them about your agency. I think it is particularly interesting that we have had evidence in most states about the needs that families have when they are placed in this situation. There has been, as you said, a range of feedback about what they want. But it is true that they want something. In Queensland we had particularly negative reports about just being given a handful of leaflets at the time. People felt that was probably not useful at all and maybe even had a negative impact. I am particularly interested in the proactive way of doing things. I know that the model that your group uses has a relatively small sample because the funding is only Perth-centric, which is a fairly small area. You would be evaluating that. Do people tell you that they do not want to be contacted; it is not what they are seeking? Can you give me any idea of the number of people who would say that?

Ms Hillman—The research suggests that 50 per cent of people generally have their own resources and support systems. They have the resilience to work through this stuff themselves. So we are really talking about the other 50 per cent. When the coroner's office makes contact, some people say, 'No, not right now,' or 'No. We're doing okay.' That does not mean that there are not people who then make contact with us. When the coroner's office speaks to them, the counsellors get in touch with the families. They will then say: 'We have this resource. Can we post it out to you?' They also include a flyer for us, so we find that people, down the track, will contact us because they have that information.

Senator MOORE—In their own time.

Ms Hillman—Yes.

Senator MOORE—Different members of the family have different needs. It is not one size fits all. We have been told today that a new suicide plan has been put out by the government. They have recently announced the successful bidder to coordinate that. It is the telethon people. It is my understanding that they are already a partner that you work with. Have you been involved with them in working on widening the service? Obviously there is a need. There is no question about that. You have already mentioned the geographic issues in your state. There is no question about that. With regard to the kinds of services that you are able to provide to people in Perth who know about you, have you been able to enter into a discussion with Curtin and the telethon people about whether there is anything in the future planning for Western Australia that would engage your kinds of services elsewhere?

Ms Hillman—We certainly have. I know that in the consultation process for the development of the suicide prevention state plan bereavement issues came up. In each of those consultations it was quite a prominent issue. We have spoken to them about it and we have had initial discussions with people in other centres, including those over east, about putting in an ARBOR model. I think that it is needed. It fits well into those larger areas, but not the rural and remote areas, which are much more difficult to service. The model would need to be looked at for applicability in those areas. In the first funding round we did look a lot more at supporting Aboriginal people bereaved by suicide and at times we had Aboriginal workers within our service. That had its own positives and negatives. We were a non-Aboriginal service so it was difficult for one Aboriginal person to be sitting in there—

Senator MOORE—and to be all things Aboriginal to them.

Ms Hillman—Yes. As for Aboriginal people, I heard this from your previous speaker. He mentioned his uncle and his aunt—and he is not unaffected by suicide—and the issue in working with your own community, when you are an Aboriginal person, is that it is your personal experience and you are supporting the family within that. It is very difficult. We did engage some consultants to develop a model of support for Aboriginal suicide bereavement statewide. That involved some local community action as well as a response team based in Perth working together throughout the state. I can provide you with that paper to have a look at. It is just a discussion paper at this stage and it has only gone out to academics and workers in the field. The next stage is to take that to further community consultation. It is with DoHA. At the end of the funded project we left it with DoHA. That is where that is.

Senator MOORE—My last question is in terms of the state suicide plan, which I think is a really good process. Have you been one of the agencies with whom they have been discussing at state level the future of the suicide strategy in the state?

Ms Hillman—We have been to some extent. I have had a meeting with Minister Jacobs. It is a difficult one. The ministerial council was previously based at the institute and had a number of key service providers and experts in the field who came together to address the issues. Bereavement support was certainly one of those issues. It has now been rejigged with the new government. I am yet to see how that is going to work in its current capacity. I am interested to see what happens after that. We have had some initial discussions. They have not been fruitful, to be honest. It seems to be: 'Oh, the federals are funding that. Talk to them about more funding rather than to the state.'

Senator MOORE—We are speaking with them tomorrow. As you said, there is this interplay between state and federal levels. It has always been and it always will be the way, but how you actually had that clearly communicated is difficult.

CHAIR—I know I am just about to take us a little bit over time but I have one further issue that I would like to follow up. A lot of the evidence that we have received indicates that the risk of people who have already suffered a suicide bereavement in the family is heightened. How do you deal with that when you are providing your support services?

Ms Hillman—As I said, our counsellors are all skilled practitioners. They all have postgraduate qualifications. Dealing with suicide risk is an everyday thing with what we do. There is not only the risk of suicide within families. Suicide within generations of families is very real. We deal with it as I hope any practitioner would when they deal with clients with suicide risk. Because we are specialists in this area, we go in knowing that these clients are at heightened risk. We know this in advance and we work with that.

CHAIR—Do you also support people that were not necessarily members of family but were close to somebody?

Ms Hillman—We have supported friends, work colleagues and people who found the body and who were no relation whatsoever—quite an exhaustive list of relationships.

CHAIR—Yes.

Ms Hillman—What I want to see for something like ARBOR is ideally that real early intervention process. Our coronial system is a legal rather than a medical system. In the US, the coroner, who is equivalent to our forensic pathologist, goes out when there is a death by suicide to the home or the scene immediately; police are there; there might be 20, 30 or 40 people there. But Frank Campbell's loss team is called out and they go out and provide initial information and support to the family. That is what we would have liked to do here. But, because of the legal system in place and the need for legal paperwork to be served and legal decisions to be made within 24 hours, we had to allow that process to happen before we could be involved. Ideally, that is what we would like to be doing—we would like to have every death by suicide attended, there and then, with family.

CHAIR—Have you done any work around the delay in response? Sometimes the coroner tells you almost immediately—from the answer you gave to a question earlier—and sometimes it is two weeks. Have you done any work around the impact of that delay?

Ms Hillman—We have not done any research, but there is a little bit of literature out there and I know that Frank Campbell, again, has done work in this area. The main, key positive that comes out is that people who are approached sooner seek help sooner. Off the top of my head, it was something like: people who were visited by the loss team initially sought help within something like 39 days whereas for those who had not had that initial contact it was something like two years or 2½ years before they actually sought help, but 2½ years down the track your life is a mess if you have not dealt with what you need to deal with. So you have a whole lot of other baggage there as well.

CHAIR—We have received evidence from a number of people, particularly parents, who have said, ‘I didn’t know what to do.’ They just did not know what to do. Some people got a few pamphlets; some people got nothing. It seems to me that that time delay is pretty critical. That has certainly come out from the evidence we have received in submissions and from witnesses to date, anyway. It seems to me that that is really important.

Ms Hillman—There were some messages relayed from the state coroner today, actually, about a particular family that we were involved with quite early on, and it has actually been written up in the police report how much they appreciated our response and our support. So there certainly is evidence for it. Frank Campbell came over and trained us to operate, as best we can, under his model regarding legal and medical obligations. He said that they have never been turned away—they have never been told, ‘We’re not interested in hearing from you; go away,’ by any of the hundreds and hundreds of families that they have visited within hours of a loss. So I think there is a little fear about that, and some people look back and go, ‘Ooh, I’m not sure,’ but most people look back and go: ‘Yes—anything would have helped. Just sit next to me or make me a cup of tea; give me some resources and make contact in a week.’

Senator MOORE—Have you got any funding or capacity to help people who are families of people who have attempted suicide, particularly the families of those people who have attempted suicide a number of times—those families that live on the edge, sometimes for a long time? Is there any capacity in your service for that, or can you just not do it?

Ms Hillman—We have not got any funding to do that. We do sometimes get calls from people who are supporting someone who is suicidal. The Ministerial Council for Suicide Prevention, previously, before its present incarnation, did seek funding from a variety of different sources. It did develop a resource—which I have here, actually—which we call in-house the ‘carers pack’, which is a bunch of information about how, as a carer of someone who is suicidal and has been attempting suicide, you can best support them and how you can look after yourself in that process. So there have been initiatives around that. It is certainly something that could be expanded, but at the moment we do not have the funding or capacity to do that.

CHAIR—Thank you. As we have with every witness today, we have gone over time. We could have kept talking with each of our witnesses for a long time. We very much appreciate your coming and sharing your information and stories with us. It really does help us to understand the issues and to frame what we hope will be significant recommendations. Thank you.

Committee adjourned at 5.09 pm