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SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Suicide in Australia

WEDNESDAY, 31 MARCH 2010

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SENATE COMMUNITY AFFAIRS

REFERENCES COMMITTEE

Wednesday, 31 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 and Siewert

Terms of reference for the inquiry:

To inquire into and report on:

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

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

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

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

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

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

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

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

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

WITNESSES

Committee met at 9.01 am

DONOVAN, Professor Robert, Deputy Chair, Ministerial Council for Suicide Prevention, Western Australia

PHILLIPS, Mr Shawn, Executive Officer, Ministerial Council for Suicide Prevention, Western Australia

CHAIR (Senator Siewert)—Welcome and thank you for coming to this hearing of the Senate Community Affairs References Committee. We are continuing our inquiry into suicide in Australia. We have already held a number of hearings around Australia, although we are yet to get to Hobart, Adelaide and Darwin. I understand you have both been given information on parliamentary privilege and the protection of witnesses and evidence. We have your submission, thank you. I now invite either or both of you to make an opening statement and then we will ask you some questions.

Prof. Donovan—I will make a brief opening statement. I am standing in for Mr John Franklyn, who is the chair of the council, who could not be here today. The council is made up of experts in suicide and suicide prevention, people who have been impacted by suicide and a number of corporate and government representatives, so not everybody on the council is an expert in the specific suicide area. I am on the committee I think because of my expertise in positive mental health promotion and general expertise in a number of behavioural areas. With respect to some of the specific suicide elements and particularly the history in Western Australia, I asked Shawn to be here so he can deal with some of those details. As I said, my expertise is across a whole range of areas, from tobacco to child abuse, racism, parenting and so on, and in this area I am particularly interested in antistigma and antidiscrimination campaigns.

Senator MOORE—You have given evidence to this committee before, haven't you?

Prof. Donovan—No, I have not.

Senator MOORE—I have met you before. It may be that I have been somewhere where you have given a talk.

Prof. Donovan—Perhaps I was saying something similar. In the Charmaine Dragun case, one of the key points that came out in some of the things that she had been writing was that she had told a number of her close friends about her problems with depression but one of the things she was really afraid of was losing her job, which indicates she did not think the wider societal norm was such that you would talk about that. Although we have made great strides with people in wheelchairs and people with intellectual disabilities getting jobs in the workplace, I do not think we have moved very far in terms of increased acceptance of people with mental illnesses in the workplace. I will talk later I think about some of the broader upstream impacts that are relevant, but I would like to turn it over to Shawn to talk more about the specifics in Western Australia.

Mr Phillips—Thank you. The Ministerial Council for Suicide Prevention is an advisory body to the WA Minister for Mental Health. In its current form it was convened by the Barnett government on 9 October 2010. I have a list of the current membership of the committee that I can leave with you. Previously the Ministerial Council for Suicide Prevention was known as the

Youth Suicide Advisory Committee. It dates back to the late eighties, when the focus was exclusively on youth suicide. That was broadened by successive governments to include all ages when the trends in the demographics of completed suicide shifted towards older age groups. Over that whole period, the ministerial council has been the driver for much of the suicide prevention activity in WA.

The MCSP, as we call it, has been charged with overseeing the implementation of the WA State Suicide Prevention Strategy, which is a $15 million commitment from the state government for the period 2009 to 2013. A key feature of the strategy will be a strong community development approach. Negotiations are currently underway to contract an NGO to do the work of implementing of the strategy. The NGO that has been appointed as the preferred provider is the Telethon Institute for Child Health Research, who I work for. Currently we are in negotiations with the ministerial council and the Mental Health Commission, which has just recently been established here in WA, over the particulars of the business plan for the implementation of the strategy.

I will now pass back to Rob to talk more about the upstream aspects of suicide prevention.

Prof. Donovan—I would like to say that suicide prevention requires a total, comprehensive look at psychosocial and structural factors. We cannot isolate one area and conduct programs there without looking at the broader factors. We know that many of the risk factors for mental illness are the same as those for suicide, and we also know that the vast majority of suicides occur amongst people suffering from a mental illness. So it is only logical that, if we can prevent mental illness or alleviate the severity of mental illness when it occurs, there will be a flow-on effect of reducing the instance of suicide.

Other areas of social inequity, in housing, education, employment and so on, also impact on people's sense of alienation, optimism for the future and other factors, and these—no doubt you have heard much of this before—also need to be tackled as part of a coordinated approach. As I mentioned previously, we know that child abuse and neglect, domestic violence, discrimination on the basis of gender, gender orientation, age, socioeconomic status, religion and race all impact on a person's mental health and wellbeing. Racism in particular has been identified as a contributor to poor Indigenous mental health and Indigenous suicide. It is quite difficult sometimes to tease these things out because, in effect, all Aboriginal people suffer from racism anyway; it is a matter of degree.

That brings me to the point about the media. I also have some expertise in the impact of the different forms of media and, conversely, how we can use the media to do positive rather than negative things. Suicide reporting in Australia, from my brief exposure to it in the last year or so, is done very well and I think it is very well controlled. The Mindframe guidelines have had a tremendous benefit there.

I think, though, that some of the depictions of people with a mental illness could be improved. I would particularly identify depictions of Aboriginal people in the news media as a major area for improvement. Just a week or so ago on the front page of the *West Australian*—I do not know whether any of you saw that—there was a picture of an Aboriginal man. He was named and described as being 'in his filthy kitchen', and the comment was attributed to him that nobody should have to live in conditions like that. It appears that he invited the paper into his home in

the hope that the paper was exposing the general conditions of towns like Roebourne. His comment was something like, 'If you show people what the conditions are like, that will help us.' The west did their best to help. Of course, the result was an avalanche of letters to the editor which clearly said, 'Well, why don't you clean up your own filthy kitchen?' There were 20 letters to the editor the next day, 16 of which were on that particular topic. Fifteen named the person and asked him to go and clean up his kitchen. Even if they had only got one or two letters, there would have been no need to swamp the press with a personal attack on somebody like that.

That sort of thing is a problem. I reacted to that and sent something out. I got a note back from an Aboriginal man saying: 'I have been walking around dejected all week about the attacks on Aboriginal people. I got your email, and I've had some faith restored. Better still, my fire is restored.' He was up and running. I do not think the media appreciate the impact that they have—not just on Aboriginal people—when they target individuals or groups, of all sorts. It has a really debilitating effect on people.

With respect to media campaigns or public education campaigns in general, a recent review looked at a number of campaigns through a number of countries. The upshot was that public education campaigns that deal with destigmatising mental illness, where there is somewhere people can go and get help and so on, have a short-term effect on people's thinking about factors, causes and so on, but, unless they are sustained, those attitudes and beliefs fall back to where they were before. They also have most effect when they are combined with on-the-ground activities like training, such as the Gatekeeper Suicide Prevention Training, of general practitioners, priests, police and other intermediaries that people interact with, and giving people who have a mental illness or their relatives and friends specific help, specific lines and so on. One strategy was an emergency card, which could be given by a GP to a person who was displaying suicidal tendencies or was severely depressed to ensure that they would have a direct line to a specialist if they were in a crisis situation. It was intended that the person's relatives and friends would know that they had that card.

About the only strategy that showed a direct impact on suicide was in Germany, in Nuremberg, which we have all heard of. Over a year or two there was a systematic reduction in attempted and completed suicides. All the other campaigns have probably been either a bit too short-lived or not comprehensive enough to show impacts on suicide, but they have shown impacts on the attitudes and beliefs necessary to change the social norm. When we are running those campaigns, it is the same with traffic accident reduction—you cannot just run a six-week campaign and then do it again the next year. You cannot ignore random breath testing, roads, seatbelts, the crash sustainability of vehicles and those sorts of things. They all work together to achieve the desired outcome. So, in programs that we do in the suicide prevention area, it is a matter of ensuring that there is comprehensive coverage and that it is sustained.

Beyondblue is a very good example of increasing awareness about depression and getting people to talk about it. Then it is on-ground activities, drawing up training materials and so on. I believe that is having some effect, although from some of our statistics that I have read—Shawn will know more about them—we do not really know how many suicides are occurring. We do not really know whether they are going up or down, because there are so many factors. Coroners' reports into whether something is designated as a suicide often come out 12 months

later or so. That not only can delay action but also brings into question what goes on in that interim to decide if something is a suicide or not.

I will end by going back to my point that if we can prevent or reduce the severity of mental illness then we will have an impact on suicide down the track given that all other sorts of things are in place as well. The area that we have included in our state strategy is also a positive mental health component. One of the campaigns I am involved here in Western Australia is the Act-Belong-Commit campaign, which is a simple mnemonic of the three domains for improving mental health and resilience. If you remain physically, mentally and socially active, that builds good mental health. If you have a good sense of belonging—lack of the feeling of belonging is one of the major contributors to suicide and a major predictive factor—and a sense of identity and keep involved with the community, friends, professional organisations, jobs and so on, it is even better for your mental health. The third is 'commit', which relates to meaning and purpose in life in the sense of volunteering for causes, taking on challenges, achieving simple achievements and contributing to a good sense of self. The more things that you successfully do, the better you feel about yourself, the greater the sense of efficacy and so on. Those are our three domains.

That campaign is running here. It is largely a community based campaign with some media umbrella work as well. Effectively, it works through communities because, while we try to increase people's understanding and awareness of what they should do individually for their own mental health and resilience, we then target groups in the community that offer activities that are conducive to mental health. They may be a surf-lifesaving club, government departments like the Department of Sport and Recreation, a tai chi group in Meekatharra, an Aboriginal arts and crafts group in Kalgoorlie, a basketball team or a dance group—whatever it may be, they can join in with it. At the same time, we are promoting community cohesion and collaboration, and those are the hallmarks of that. So I see that as always sitting as part of whatever we do.

There are a couple of things that are particularly relevant here and personalise that. One of the letters we got back after we started the campaign in northern was from a woman who said she had just moved here. She was recovering from a mental illness. She did not know what to do. She saw our ad in the paper and got involved with our local project officer, who had a cup of coffee with her and found out she had some writing skills and organising skills. She put her in touch with the health, healing and harmony event that they have up there. She was organising that. Through that, she met an old Aboriginal woman and got talking to her. She is now writing that Aboriginal woman's biography.

Another example is that at the Suicide Prevention Australia awards, where I was asked at the last moment to fill in for John Mendoza to present one of the awards, a young woman came up to me and said that she used to be in one of my MBA classes at the university. I did not recognise her, but I said, 'How are you going?' She said: 'That's not the reason I came to say hello. The reason is that I'm a suicide survivor. I care for a suicide survivor. I was sitting around at home—I can't work—and did not know what to do with myself. I saw your ad.' What she took away from the message was the volunteering and the commitment. She went to the website. She said she was now volunteering. She was a high-level finance person before her attempted suicide and she was now working with organisations, doing their accounts and so on.

One of the points there is that when we look at the top end of prevention, because we are putting mental health in a very positive context people with mental illnesses in recovery stages are responding to the campaign as well. One of the good things about that is that we get a lot of people who respond who would not go to a psychologist or psychiatrist or have been there but have found that it has helped them control their illness but not enjoy a good quality of life. We attract those people too. We can in fact have a trickle-down effect of an early intervention, preventing people going on to a mental illness or other things.

I might end there. I will go back and see if Shawn wants to add something.

Mr Phillips—No, that is fine.

Senator ADAMS—To come back to some of the data, quite a lot of evidence as we have moved around the country held that nobody can really put a finger on exactly how many suicides there are. I come from rural Western Australia, so there are single-tree accidents on a straight road. There is always that question mark in a small community where everyone knows each other: 'How could he'—or she—'do that?' Why would they run into one tree on a clear road? The question mark is there and the family suffers from it as well. It is the stigma, whether it is erased or not. It happens to everyone. There have been a lot of queries about the statistics and whether we really do know how many people have been involved with suicide or how many people have question marks in coroners' findings. Could you comment on that from the institute's point of view with your research?

Mr Phillips—Certainly. Our main involvement in this area goes back to the late eighties. We started a project working with the coroner's office. We got ethics approval to have one of the staff—it was not me at that stage; I had only been with the institute for a few years—based out of the coroner's office. They were given access to all the closed files where the coroner had made a determination that suicide was the reason for death. We have been collating what they call psychological profiles or psychological autopsies of every completed suicide in WA since 1986. We have a database of nearly 5,000 cases. That is a very rich database in terms of understanding what was going on in the life of each person who has committed suicide over that time, but there certainly are issues around, for example, those files where there is no determination. The file then is not closed or is called something else other than suicide. So I can talk about the data that we have in WA, but it does not directly address your question.

I might refer you to a number of other submissions that the committee has already received, because I think there is some really interesting material that you already have before you. One is the national committee that Suicide Prevention Australia set up on the standardisation of reporting on suicide. I think the work plan that is in that submission is worth considering. I was on that working group and still am. The other submission that is worth mentioning is the ASRAP submission from Diego De Leo's team over at Griffith University in Queensland, because what they have done is quite unique in Australia. As I said, our collection includes only closed cases where the coroner has determined a suicide. What they do there with the Queensland Suicide Register is have a system where they get all the primary data from the coroner's office and have a coding for suspected or possible suicides as well as those that are officially determined as suicide. I think that is moving more into the area that you are talking about. They would include factors like a history of mental illness and look at the relationship between different things that we understand from our study of completed suicides are important factors for those cases that

might not be so obvious. They have some other categories that they can put things into which change the way that the numbers come out at the end of the day. Diego has published a number of reports on the work from the Queensland Suicide Register.

In thinking about how to address this issue on an Australia-wide basis, those two submissions are really worth consideration. There are certainly a lot of areas within the system where the process, to a certain extent, undermines the final outcome. There is some good work already underway. The current changes to the ABS way of recording suicides will certainly have an impact on things. The National Coroners Information System is based on information that comes from the coroner's office.

The final thing that I would say is that state coroners have a huge influence over this process. You have Alastair Hope coming as your final witness today. I encourage you to ask him about his views on bringing closed findings. I know, from what I have heard from him in the past, that he is very keen on, wherever possible, trying to bring closure to families so that they know, as much as possible, what the circumstances were.

Senator ADAMS—In Western Australia, what percentage of people who commit suicide have had an underlying mental illness in comparison to people who commit suicide just out of the blue, for no reason and nobody has realised that they are perhaps depressed?

Mr Phillips—I will leave a copy of this with you, and I can send it through electronically. This is a PowerPoint presentation that some people I work with, Kate Miller and Deborah Robertson, prepared for forums such as this. It basically is a snapshot of some of the key questions that people ask about the data that we collect. I will read to you from a graph here. This is looking at diagnosed psychiatric conditions. It needs to be acknowledged that there will be lots of cases where there are undiagnosed conditions as well. Just looking at the diagnosis rates for males and females, you can see that the graph has one very long bar and a bunch of very short ones. The long one, as you would probably guess, is depressive disorders. The rates are quite different, almost two to one female to male. The figure for males is 23.67 per cent. It does not actually show the period, but I believe this would be 1986 to 2006, so the full cohort over a 20-year period. It is quite a large amount of data. So 24 per cent of males and 47 per cent of females who committed suicide in WA over that 20-year period had a diagnosed psych condition and particularly depression.

That raises a few questions. Why the difference in diagnosis rates between males and females is one of them. Some people's theory is that it relates to men's willingness to seek help for their depressive illness. We have been involved in a number of initiatives looking at the issue of men seeking help and how to influence that. That is probably the hardest data that we have on that topic. All the other ones are around the five per cent or less rate. In terms of the order, schizophrenia, drug abuse, personality disorders, alcoholism, anxiety disorders and adjustment disorders all figure across the scale. I will leave a copy of that for you so that you can look at it in more detail.

CHAIR—While you have the figures, with regard to completed suicide and attempted suicide, in the rest of Australia there is a much higher rate of female attempts and a higher percentage of males completing. Is it the same trend in Western Australia?

Mr Phillips—Yes. One of the other graphs that I will leave with you talks about that. That is pretty much the case. This graph shows standardised rates for 100,000 people. It is about 20 per 100,000 for males and about five for females. That is typical of what you get in most jurisdictions in Australia—about four to one in terms of completed suicides.

In terms of deliberate self-harm admissions, the source of the data is different—it is hospital data from the Epidemiology Branch in the Department of Health. This is basically a sample of 31,000 deliberate self-harm admissions. So that is focusing on hospitals on the assumption that the more serious end of deliberate self-harm or suicide attempt would get to the hospital, but we acknowledge that there would be lots of others that do not. The Department of Education in WA, for example, is keeping a database now on self-harming behaviour in schools because a lot do not end up getting to the hospital. In terms of male to female, from 1996 to 2006 you are talking about 19,000 females and 12,000 males, so almost two to one females to males. It is the same pattern. It is pretty consistent in most developed Western countries.

Senator FURNER—How is the data on self-harming collected in the schools? Is it based on teachers reporting evidence of children in the schools self-harming to the principal and then to the education department?

Mr Phillips—I cannot tell you whether it goes through the principal or not but they have set up a database and have protocols in place to record instances of self-harm. I would imagine that the school psychs would be the main people involved in the maintenance of that database. Chris Gostelow is the manager of psychological services in the public school system in the WA Department of Education. He would be the best person to talk to to find out more or I can find out more for you and forward that to the committee if you like.

Senator ADAMS—As we have moved around, the evidence with the schools has been that they really do not want the word 'suicide' used. What support programs have you got in Western Australia that are carried out in the schools? Do you use the word 'suicide' or 'self-harm'? How do you actually approach it?

Prof. Donovan—That is probably better answered by Shawn, but I am aware of the Aussie Optimism Program in Western Australia, which is teaching more resilience, positive mental health and coping skills. The bullying program is rolling out—if we see bullying as a precursor of them having mental health problems or at least feelings of despair and those sorts of things. They are not positioned as suicide prevention in a specific sense, but those sorts of programs all contribute to suicide prevention.

On your question whether we mention the word 'suicide', the German program I mentioned earlier that was successful in reducing attempted and completed suicides never actually mentions the word 'suicide' in the public education publicity, posters and so on. It really focuses on the GPs and suicide as a result of depression, anxiety disorders and so on. People within the community, the gatekeepers, the multipliers or mediators, as they call them, are very much informed that mental illnesses, particularly depression, are major risk factors for suicide. Hence, that is what they are sensitised to look for. But most of the public information in that program does not actually mention 'suicide'. It is an issue for schools as well as for the general public.

Mr Phillips—The issue you raise is a good one. It relates to some research that was done about programs where groups of adolescents were brought together to discuss the topic of suicide. Some findings of these research projects indicated that they can actually do harm in the sense of influencing vulnerable people. Parts of the groups involved in the discussions about suicide may already be suicidally ideated or have made previous attempts and that sort of thing. Having these conversation groups was seen as potentially contributing to risk to vulnerable populations. That is what is behind this whole issue of: should you talk about suicide amongst groups of schoolchildren or not? The overarching philosophy or principle of work in this area is: do no harm. Erring on the side of caution, people tend to focus on positive mental health as opposed to talking about suicide.

But then that raises the issue, which has no doubt come up a lot with this committee, of the importance of getting people talking about it, of destigmatising suicide. It is a balance. The research into risk factors talks about the taboo against suicide in our society as in fact being a protective factor. But then, if something is under the carpet, people cannot talk about it when they are feeling at risk and get the help that they need, and there is the risk of harm that way too. So that is the issue behind it.

In terms of the main programs that are happening in schools, in WA probably the most widely known one, as well as Aussie Optimism, would be the MindMatters program—MindMatters, KidsMatter; there is a whole suite of programs. They were started through the national principals association—I can't remember the exact term for the organisation, but they were developed and the National Suicide Prevention Strategy strongly supported them. They have been very successful and have a number of different incarnations around the country. That is another example of a positive mental health program which does not focus on suicide but focuses on how to maintain positive mental health.

Senator ADAMS—Have you done much research as far as the exposure to the internet and Facebook, with respect to things like copycat suicides or just the ideas that come through with the enormous amount of communication there is now in comparison to the way it was before? Have you done any work on that?

Mr Phillips—At the institute there was a project looking at developing basically a guide for young people to use the internet safely and wisely with regard to the issue of suicide. There was lots of good advice on how to surf safely in that situation. In terms of research about the impact of the internet I would have to take that on notice and get back to you. There certainly has been some, but I cannot actually—

Senator ADAMS—I was thinking more of teenagers posting things like, 'I'm so depressed and I really feel like I don't want to go on', and all the rest of it, and all these friends see it. Is there a guide anywhere as to how that person can be rescued, if someone reports it or gets with them? For a teenager to receive something like that, they would be thinking, 'Goodness me, how can I help? What can I do?' Is there any sort of guide in that respect?

Mr Phillips—So, you mean what a young person can do if they come across—

Senator ADAMS—Just a casual comment on Facebook that they are depressed and they are feeling they just do not want to keep going. They could be stressed out of their minds about the

TEE, for instance, and all of a sudden it is just too much. How do their peers deal with that issue? Is there any sort of guidance, a link that could be followed for someone to know what to do? It is a bit like one of your mates having a drug overdose and how to deal with that. There is quite a lot of guidance as to what to do, with first aid or whatever and looking after your mate. I am just wondering now, with the fact that the internet is going so crazy, whether there is a way that, if that came up, somebody could immediately get help for that person.

Mr Phillips—There are certainly lots of resources already online. Reach Out is one project that comes to mind, and the work that the Inspire Foundation do in terms of engaging with young people in an online context. The issue that you raise is certainly one of concern. In some situations there have been websites where people are actively encouraging other people in their suicidal behaviour. That is probably an extreme example, but there certainly have been cases where that has been known. In WA if you were to put 'suicide prevention' into Google—I am not sure whether this is still the case, because these things change over time—one of the top websites you would get would be the Ministerial Council for Suicide Prevention website. There are a number of resources we have developed that are available online. We have a community website, basically, which in very plain English talks about identifying risk factors, where to seek help, how to support someone who is suicidal and all of those sorts of things, in a very youth friendly sort of way.

There is a resource we have developed—I will get a copy for you—which is an information and support pack for people who are concerned about somebody who is distressed or suicidal. That is more of a comprehensive resource for, say, parents and carers who might be concerned about a teenager who is showing signs of suicidal ideation or whatever. There are quite a few resources out there. We have partnered with the Office for Youth in WA to develop a suite of youth friendly resources for how to support someone who is at risk. So there certainly are things there. The question always is: how do you get them out there in a way that young people who need them most are going to be able to find them? That is a perennial issue. Rob might have some more views on that from a marketing perspective.

Prof. Donovan—That is a good point that you raise, but the key thing is that there are areas where kids can go for help—the Orygen group have got things online. It is how you actually get to them. The Centres for Disease Control and Prevention in the United States is one of the leading organisations in trying to use what we call 'social media'—Twitter, Facebook and others—to get out their pro-health messages. You can pay Google so that particular keywords will be the first to pop up, or you can look for what are some of the key phrases that kids might use and build them in to your site so that they will appear. You can pay people to go on to Facebook and search for comments like that and then join up with those people. One thing we are not particularly aware of is that many of the commercial companies are actually paying people to tweet and build Facebook sites and so on. They appear to be just consumers but they are in fact spreading the company message. In that sense, there is no reason we cannot do that but in an open sense. The Victorian Traffic Accident Commission has a very big YouTube site. You can look at all their ads and things there. But the key element is: how do we link the person with the comment or the direct question? There, we need to look at the people who design those things. In a sense, in the end it comes back to paying for it.

Senator ADAMS—On the pressures with regard to year 12s, what programs are WA schools using to try to keep students on an even keel rather than getting depressed because they are

studying too hard, or everything has just got beyond them and everything is just a blank wall and they think, 'I'm never going to get there,' and that type of thing? Do the schools do anything in that respect before the students finish?

Prof. Donovan—I should imagine that the school psychologists and counsellors would be, but I am not familiar with any specific programs.

Senator ADAMS—I just wondered whether there was a state program where the year 12 students could have some sort of assistance as to what to do and how to deal with something when it gets too hard. It always seems to be that particular year, with the hormones and everything else going on, the pressure of their exams and wondering whether, if they do not get through, what they are going to do and how they are going to deal with it. It all becomes just too hard.

Mr Phillips—I can look into that and get back to you. I will contact the Department of Education and find out what programs they run. Having raised three kids and gone through the year 12 experience, I suspect there is always room for improvement.

Senator ADAMS—That is right. Coming from a rural area, at the moment I am really worried by the over-55 male cohort. You are probably aware that Lake Grace has had three bad seasons. Finance is a huge problem and a lot of the younger people are not staying. The average age of a farmer in Western Australia at the moment is 58 years of age. It really worries me as to how you get to those people, because often they are so isolated. They are working all the time; they do not go to the pub anymore. All that sort of thing is gone because they are scared that they will get caught drinking—maybe not over the limit. Their whole social structure seems to have fallen down, so a lot of people are really becoming more and more isolated. What programs do we have to deal with those people to keep them in communication?

Mr Phillips—Here in WA there is a bloke by the name of Julian Krieg who operates from Wheatbelt Men's Health. He has done some work with the Kondinin Group and put together a DVD. He is a bit of a legend in terms of his work with men on the land. A lot of it is about cultural appropriateness in the way that he approaches his work with men, and creating opportunities to engage with guys and get them talking. Encouraging them to talk with a mate is really his main message.

We did a little bit of research looking at suicide trends in rural areas. It was a bit surprising for me: it was not so much farmers that were committing suicide, although there are some issues with the classification of different people's employment. It made me wonder if there is the other side to the story as well—that they are a pretty resilient lot, even in tough times. Often their strengths come to the fore there. The research certainly acknowledges that there are higher rates of suicide in rural areas. Young people in rural areas are a particular focus of concern, but also older males, which goes with the cultural stereotype of being stoic, not expressive and not talking about it when things get tough. Some work has happened through rural counselling services. The Commonwealth government, I think through a sub-branch of the Family Relationship Services Program, had some extra counsellors go in in times of drought in rural areas. They would probably be the main things to come to mind. You may know others.

Prof. Donovan—It is a very difficult issue. My experience with men is that it is very difficult to get them to come along and talk about their health, but after 1½ hours you have to kick them out of the room. It has always seemed to me that what we are looking for is the incentive or the hook or what or who might get them to come in. In the same way that, in the rural area, you would look for the opinion leader on tractors or headers or harvesters or whatever, we are looking for the opinion leader who might be able to get on the phone and talk to blokes and get them to come to a meeting. In my experience, with the things that we do, we do not sustain them and we do not keep resourcing them and they cycle and somebody starts something else up. It is difficult, but there are ways; we just have not tried them.

Mr Phillips—There is one program that comes to mind. In Albany a few years back—I cannot remember the exact year but I would say it was in the late nineties—long-range forecasting was predicting a drought. What they did down there was a very simple response. They basically put one person in the field to start working collaboratively with all the different agencies, government departments, community groups and everything in the area to develop the capacity to respond in that time. The results were certainly very good. There was no sign of an increase in suicides in that particular period and a number of the programs that were developed in that time were quite sustainable. Certain elements of that are part of the WA strategy in terms of developing those community action plans. This one was particularly focused on a drought that they knew was coming.

Senator FURNER—I was really interested in the part of your submission dealing with immigrants. It was stated that a quarter of the population that suicide in Australia come from overseas. You point out the countries of origin and I think Russia was the highest, at 36 per cent. The rate of suicide is reflected in the country of origin, not necessarily the country where people they take up their next livelihood. You go on to point out that 60 per cent of these deaths are of people from NESBs. If you have the statistics, I would like to know whether the figures for suicide in Australia are reflective of the figures for the country of origin. Where do we need to tidy up areas of notification or education? Is it by producing documentation in people's own language and those sorts of areas to hopefully get through to them with educational needs?

Mr Phillips—I would add to that that the area that is probably a little bit under researched is the impact of the experience of being a refugee. I think the comment is generally that suicides tend to follow country of origin, so people who come here from home countries with a high suicide rate tend to replicate that in Australia. I am not 100 per cent clear as to your question. Are you asking what the source of that research is?

Senator FURNER—I can see the source of the research. I want to know whether it is reflective. Say, for example, we had 10 per cent of Russians in Australia. Is the suicide rate 36 per cent of that 10 per cent that reside in the country, as is reflected in your evidence?

Mr Phillips—I am not sure.

Prof. Donovan—I think you are saying in a sense: what is the added risk of being a migrant over and above what the rate back home is?

Senator FURNER—Yes.

Mr Phillips—I do not know that there has been a lot of research on that topic in Australia. I think most of that information comes from overseas research. I am not sure that I can answer that one. I can certainly take it on notice and get back to you.

Senator FURNER—The other part is the 60 per cent of the deaths and also the 25 per cent in Australia being from non-ESB. So are we failing in that department as a result of not providing educational services to assist people's needs as to where they can get help in those sorts of areas? What is the reason why that figure is so high?

Mr Phillips—That figure sounds very high to me.

Senator FURNER—It is on page 22 of your submission. It talks about the 25 per cent of suicides in Australia being 'by people within the migrant population', with 60 per cent of those deaths occurring among people from non-ESB.

Mr Phillips—It is 60 per cent of the 25 per cent of suicides. I know the reference. I will have to get back to you on that because I will need to go back and re-read it.

Prof. Donovan—That would have to be related to what is the proportion of migrants with a non-English-speaking background anyway. I guess it is put like that because the percentage of non-English-speaking background is much lower than that of English-speaking background and therefore there is a point of significance there.

Mr Phillips—I will have to look at that more.

Senator MOORE—I have a question to do with support for families in terms of working through the process. We had evidence yesterday afternoon from ARBOR, who were very impressive in terms of the information they provided. They did say that they are only currently funded to provide services for people in Perth and they have got people from Western Australia talking about how Perth is only a very small part of your very large state. I am wondering as to the new strategy—and I think that it is splendid that the Western Australian government have produced this strategy and that they should be applauded for it—what is the process in terms of getting that kind of support for the families who go through such trauma? We have had that in evidence in every state that we have been in. We have had some people from the family networks talking about it. I am interested in what the strategy is for providing support to families in your massive state.

Mr Phillips—There are probably a couple of things to say in response to that. One thing is actually an issue, I think, of collaboration between the Commonwealth and the state, so I might start with that one.

Senator MOORE—Just a small issue!

Mr Phillips—Just a little one—that is right. Part of the reason why ARBOR is only in the metro area and not elsewhere is that a decision was made under the National Suicide Prevention Strategy to fund a different organisation to run programs in bereavement support in the Kimberley and the Pilbara. I do not know if you are aware of that, but that is a stand-by project. That decision happened out of Canberra with virtually no consultation with the state at all, not

that that is anything against the stand-by project or the work that is happening in the north of the state.

Senator MOORE—It is how that is done.

Mr Phillips—If we are talking about enhancing the capacity across the state then I think there is room for development in terms of the way those planning decisions get made. There has certainly been talk between the state Ministerial Council for Suicide Prevention and the Commonwealth office of DoHA with regard to developing a memorandum of understanding or some sort of closer relationship in terms of planning for future service delivery. So that is part of the equation.

One of the other things that ARBOR did in the first round of funding—and Sharon might have talked about this yesterday as well—was to specifically look at Indigenous bereavement support. We had one Indigenous dedicated staff person on the team and we went through about three in two years. Basically, in the exit interview everyone said that the level of grief in the Indigenous community was so vast, even just in the metro area, that it was unconscionable to continue with that approach. So we hired a couple of them, with Pat Dudgeon who set up the Centre for Aboriginal Studies at Curtin University, to take the ARBOR model, to have a look at it and to talk to other people in the Indigenous community and ask the question, 'Is this really the right model for the Indigenous community?' A discussion paper was formed out of that—which DoHA has a copy of as well—and certainly the ministerial council is interested in how the issue of bereavement support might be progressed in WA. Particularly in remote Indigenous communities it is a major issue. With regards to bereavement support across the state, yes, it is true that presently it is a very small part of the overall geographic spread of this massive state but the majority of suicides also happen in the metropolitan area.

Senator MOORE—Perth has the largest population. We are from Queensland and it is totally different there because we are very much more decentralised.

Mr Phillips—There are big regional centres in Queensland, yes, and that is a big difference. The population centres are all quite small and dispersed in WA. ARBOR does have contact with people outside the metro area. One of the proposals put forward as an enhancement to ARBOR was basically a training program to go out and train people in regional areas. So while we might not be able to have an ARBOR in every regional centre, we can certainly identify those people with the skills in counselling around suicide prevention, or the potential to upgrade their skills, in regional centres and then develop relationships with those people so that when we do get calls for bereavement support in regional areas there is someone we know in that area that has been trained and has the skills to support them locally. That was one of the suggestions for how to deal with that situation. It is always incredibly difficult in terms of replicating programs in regional areas in WA. The cost of accommodation alone in the northern parts of the state is just astronomical.

CHAIR—If you can find it. There are not even houses there for people to access and pay the astronomical rents.

Mr Phillips—It is a huge issue.

CHAIR—Yes, it is, and it has come up on this committee and another committee that most of us are on as well. Regarding support for Indigenous communities, we heard from AHCWA yesterday and also Darryl Kickett came in from the Nyungar Health Council, and we largely focused on issues around Albany and Narrogin. They are still struggling for support there. We have still got Oxfam funding and Darrell Henry comes into Narrogin part time. There is not adequate support for social workers and there is still not a female support officer there. We just lost Wayne from there, basically through overwork and the burden of dealing with the issues. What is the situation for putting more resources into that area, but also the general support for Aboriginal communities? Are we boosting that up? It seems a ridiculous situation where we have to rely on Oxfam to support a worker—and we are talking about two hours from Perth. Where are we up to?

Prof. Donovan—I guess one answer to that is that the suicide prevention strategy has been launched. A process was put in train to appoint a NGO to begin to implement the strategy. Things are in abeyance there between the mental health division and the appointment and so on, so really we are treading water at the moment. Until that is resolved then the strategy is still sitting on the table. As to your specific questions, the council was set up in fact to make decisions about where the resources might go to particular communities, and I certainly know that Narrogin has been flagged in our preliminary discussions. But until the strategy implementation gets the go-ahead, as I said, we are treading water.

CHAIR—The institute has been appointed as the successful tenderer. How long is it before those issues are resolved? Sorry, I should rephrase that—it is not issues to be resolved. I understand it is a substantial process that you have to undertake, but is there a time frame on it?

Prof. Donovan—I do not think there is a specific time frame. I would hope that it does not go on much longer, certainly not much more than a month or so, but there is no time frame.

CHAIR—In terms of the money that is coming through COAG for closing the gap, AHCWA said to us yesterday there is $44 million, of which $22 million is parked at the moment but the other $22 million was going to be delivered to the state and now they have realised it should be delivered through community based organisations. How does that process work with the strategy process? Will it be delivered through the strategy? Is that how it is intended that it should be delivered?

Mr Phillips—It is a good question and we are still working through some of the details of that. I met with somebody from Premier and Cabinet yesterday to talk about the state government's approach to coordination of whole-of-government issues, because that is the category that that fits within. There are a lot of things that are happening. I think one of the absolutely essential goals for the implementation of the state strategy is to do a better job of whole-of-government coordination around all these pots of money that come in for specific sets of objectives that are actually very related and need to be integrated.

I heard Ian Webster, the Chair of the National Suicide Prevention Advisory Council, speak at a SPA policy forum in late December and he was talking about the three principles that the National Suicide Prevention Strategy is moving towards. I thought they were brilliant: alignment, leverage and embeddedness—the importance of suicide prevention not being seen as an item out there but actually embedded in everything that we do. The risk factors for suicide are

the same risk factors for most of the social problems we are all trying to address from all our different directions. How to pull that together and how to make it work effectively is a great challenge. For us it is a challenge at a number of different levels.

There is certainly cooperation and coordination between state government agencies, but there is also the role of local government. In WA a new public health act is being launched. One of the important things about that is that drugs and alcohol is one of the priority areas and is certainly a serious factor in terms of suicide. Then there is the relationships between the National Suicide Prevention Strategy and the State Suicide Prevention Strategy. Certainly a central plank of the strategy is to work in a whole-of-government manner. So I would say absolutely yes, what Darrell was talking about yesterday is something that is of absolute central importance to the suicide prevention strategy, and we have to work together.

CHAIR—Okay. The Oxfam funding and one other element of funding, which I think is the funding for the social workers that is going through SWAMS, finishes on 30 June 2010—in other words, in three months time. Is the state going to be in a position to adequately fund support services in Narrogin come 30 June this year?

Prof. Donovan—I cannot speak on behalf of the state, but in my position on the council I would certainly be pushing for that.

CHAIR—Thank you. I realise you cannot answer beyond your capacity and represent the government. It is just that I and this committee and another committee that many of us are cross-members of have taken an interest in Narrogin for quite some time. It seems to me they are always having to scout around for funding, missing out on funding and having to tack together programs, which is not a way to address these long-term issues.

We were told by the Brain and Mind Research Institute that you were running some interesting programs. I am keen to get a bit more detail on the nature of those programs. I have heard other people speak highly of them. What are the key factors that make them successful?

Prof. Donovan—I guess the Act Belong Commit program is the one that you are talking about. One of the primary factors is that we did a lot of research before we began. We talked to people all around the country about their perceptions of mental health and what it meant to them. In fact, the words act, belong, commit bubbled up from the research. We found out that people did not think about mental health that much or if they did they thought mental illness. So when we said, 'If it were mental health week next week in Bunbury, what would be happening?' they would say, 'Yes, you would have psychiatrists and be talking about schizophrenia and bipolar and so on.' So we knew we had to reframe mental health from meaning illness to positive mental health, which is why we called ourselves Mentally Healthy WA, because mentally healthy has all positive connotations. So we had that very basic research and we discovered people have good intuitive knowledge of the things they could not do and should do but they just did not think about it on a daily or even a long-term basis. So if you talk to people about protecting their physical health, they know they should not smoke, they should exercise, they should eat the right foods, otherwise they will get heart disease, diabetes and other sorts of things. They may not always behave themselves but at least they know and are thinking about their physical health and what they can and should do. But in the area of mental health it was a bit of a blank—I can relax if I feel tense, I can go for a walk if I am anxious, but not in the same sense of a longer term

thing. It was reactions to immediate moods. So our program is designed to put mental health on the agenda in something that is a lifelong capacity and that there are things that you can and should do proactively. That was one of bases of it.

The other thing is that we talked to mental health professionals before we started, because one of the common problems in these areas is that you can go in well-meaning and mount campaigns in different areas but you have not talked to people in the service delivery, who are already overloaded and so on. We found that the mental health professionals were very supportive because what they could see happening in the physical area was not happening in the mental health area; nobody was trying to stem the tide further up. So we had good support from them.

We went into six country towns and talked to people down here before we even began the program, because we thought we needed to pilot this, the first time it had been done. We talked to people there from historical societies, local government, local health people, tourism operators, tai chi people, saying, 'If there were a mental health campaign, something like this, would you be interested, how would you be interested and what would you want out of it?' In a sense people in these towns get a little sick of people from Perth coming down saying, 'Here's a campaign that is going to fix your health in this sort of area.' Our approach was, we will have a project officer in the town but they will set up a steering committee based on people in the town who are interested.

Our first launch was a community forum where the community decided what would be their priorities: did they want to mainly target young people to get them inclusive, seniors, all of those, or whatever it might have been. So the local towns had a lot of autonomy in what they did. We provided them with the usual bag of goodies of merchandising and so on. They had water bottles, posters, balloons and things like that, which for local groups in small communities are actually quite good because if someone comes in you give them a T-shirt or some such and that is pretty positive. More importantly, what we did is also say, 'Look, we will help you with writing up funding applications, say, to the department of arts or Healthway or wherever you be able may be able to get funds for your own organisation or your event.' We said, 'We will be running press ads in the local newspaper; that will trigger reciprocity with getting articles in. We will work with you to get publicity for your organisation at the same time as ourselves.' For example, we read an ad called 'Feeling blue, act green', which was based on if you are feeling a little down getting out in nature and walking or doing some exercise and so on is actually good for you mental health. They were called green garden prescriptions.

In that particular case we ran the ad. We did a press article in which I talked about the psychological benefits of contact with nature and then we had a picture of the Esperance Weed Action group, a volunteer group, out on the dunes doing things. We talked about how you can not only take a walk in nature but form a group to get out there and volunteer. We illustrate the Act Belong Commit principles in that sort of thing. The Esperance Weed Action group got some publicity that they might not otherwise have got. They may have attracted some volunteers. It worked very much on a community basis.

If I may take just one more small thing, in one of the local newspapers we had a club-of-the-month feature. The project officer helped the club write up a little blurb and we got our logo in it. I think they began with 12 women and 24 kids in the club. It was a group for people newly arrived in town. Maybe the husbands were flying in and flying out and the women were left at

home looking after the kids. We ran them as the club of the month, and in the next few weeks the numbers went up to 58 women and about 200 kids. These things are good in that nobody has to operate them; they can self sustain. There is a lot of feedback like that.

When we went state wide in 2008, the WA Country Health Service wrote it into the job descriptions of their health promotion people right throughout the country areas, and then it was a matter of people approaching us. We do not have a big organisation or large funds. We now have five local governments, from Rockingham in the south to Wanneroo, that sign a memorandum of understanding. Rockingham is particularly supportive. They have assigned a 0.5 project officer to run the Act Belong Commit campaign. One of the things out of that was that a woman saw something about it in the local paper and she has formed a group which she calls PRAMS—I forget what the acronym stands for. Basically, it gets a group of women to go out walking and clearly it has got something to do with taking along preschool kids. So it triggers actions by itself, which is what we want.

So we have the five local governments signed up. A couple of women's health groups have signed up. We have done a program with the Department of Sport and Recreation in which they used our television ad as a doughnut. We broke in the middle with a couple of local celebrities who said that joining our club is a great way to act, belong and commit and that you can join a club at the Department of Sport and Recreation's website. Up came the website and so on. They went from a hundred kids a day or a week to 400. It quadrupled when they ran that ad, and hopefully that then flowed through to people joining a club.

We have two aims. We want people to learn about mental health but, at the same time, if they do things that are good for their mental health we do not really care whether they know why they are doing it. If we can get people to join clubs, to join in and so on, then we have achieved part of our aim.

Surf Life Saving is another group that has joined up. We spread to Victoria after I gave a presentation in Sydney last year. Toorak College on the Mornington Peninsula are now an Act Belong Commit school and they are embedding the principles of Act Belong Commit into what they do, particularly the community part, so that the kids are now more geared up to go out into the community and do things. Through them there is now another women's group with 13 health providers within a particular geographic area signing an MoU.

As I said, it is community based with an overarching umbrella of some media advertising and publicity. We are working on the basis that there is individual resilience and there is community resilience. When we look at actions here, like community action plans, clearly stronger and more cohesive communities will be in more of a position to act on those and do other things. So it acts as a social environment that we are trying to build the capacity of and strengthen.

CHAIR—Thank you very much. That rundown and your time is very much appreciated. Mr Phillips, we have given you some homework.

Mr Phillips—You have. I have a list here. I will get a transcript from the session and make sure I have not missed anything.

CHAIR—We can clarify it as well. Thank you very much for your time.

Mr Phillips—Thank you.

[10.15 am]

ALLEN, Mrs Jennifer Anne, Chief Executive Officer, Youth Focus Inc.

MARSHALL, Ms Nicole Anne, Acting Manager, Youth and Family Services, Youth Focus Inc.

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

Mrs Allen—Yes.

CHAIR—We have your submission. I invite either or both of you to make an opening statement and then we will ask you some questions.

Mrs Allen—I will just give you a little bit of information about Youth Focus. Rachel, I know that you have some and I think probably Senator Moore does as well—I think I met you in Canberra.

Senator MOORE—Absolutely, yes.

Mrs Allen—Youth Focus was established in 1994, specifically for youth counselling, family counselling, peer support programs and training and mentoring for young people 12 to 18 years of age. We offer these services at this particular time to approximately 1,000 young people and 200 families, but each year we turn away many who need our help, and there are those that do not ask for help.

In an average year 12 classroom, at least one young person will have attempted suicide and at least seven will have experienced a mental health difficulty, but only two will have sought professional help. We should ask ourselves why, in a society like ours, where most of us feel we live in a lucky country, so many of our young people deal with such devastating issues.

Youth Focus works therapeutically and holistically in a non-time frame with young people aged 12 to 18. More recently we have had Focus Plus, which is another program, working with people aged up to 25. Youth Focus is for young people who are showing early signs of suicide, depression and self-harm. In Western Australia we have a proven track record and believe in operating with partners like Inspire Foundation, Lifeline, Orygen and beyondblue on the eastern seaboard. We strongly believe in working together, not just as a single unit.

We have been recognised as an innovative and forward-thinking organisation. We have grown since 2000, when we had three staff and a budget of about $240,000, mainly in government funding, to having a budget now of $3 million and almost no government funding. We operate in metropolitan Perth and in the Peel area in three locations, which include Rockingham, Kwinana and Mandurah, and we have an office in Collie and one in Bunbury. In mid-April we are opening one in Albany.

The other thing I want to bring to the floor is that I have recently been appointed to the SPA board nationally. No doubt you have had submissions from SPA regarding the statistics that many in our industry are led to believe are falling in the area of suicide. I think it is fairly amazing. I questioned why the ABS 2007 statistics show a five per cent rise overall, and coroners have agreed that in all probability the reported stats are some 30 per cent below what they should be. I think this is probably going to cause a lot of distress. I have to question how we are going to handle it within our industry and how we are going to introduce that.

I would now like to introduce Nicole. She is the acting manager of youth and family services and so works very much at the coalface. She intends to portray the areas that Youth Focus believe need to be addressed and which we have gleaned through the work that we do in face-to-face situations with our counselling and our peer support programs for the young people that we see. I will hand over to Nicole now.

Ms Marshall—I would just like to make clear that my background is as a registered psych, so I am coming to you today from the point of view of somebody who works on a day-to-day basis with suicidal young people. I am not an academic or a researcher as such but I think I have a pretty good grounding in some of the issues that are happening. I would like to add as well that I do not necessarily think that there are any experts in this area. It is a very complex issue, and certainly all the young people that I talk to have a very personal and individual story to tell. I would like to offer some of my thoughts on this topic, and I thank you for the opportunity to do so today.

I believe the role of agencies offering prevention and early intervention in the area of suicide prevention is crucial. The sorts of prevention measures that we are talking about are going into schools, running workshops, having conversations with young people about what depression really is and about mental illness and giving them opportunities to open up and talk about it. A lot of the workshops that are currently occurring in schools are quite didactic in the sense that they are information, information, information, and there is not really a lot of opportunity to get down and have a talk from people who have experienced these sorts of issues and have them tell their stories in a narrative approach. I think that that would be a really fabulous way for these kinds of things to evolve.

As an agency, at the moment we have one person fulfilling that role—going into schools and doing that kind of training—so it is barely enough to break the surface of what needs to be done. I feel that programs that support agencies to do more meaningful prevention work would be highly valuable. Generation Y and gen X kids need a bit of a different approach in terms of technology in different ways to get their passion flowing and their creativity going. I think we are still trying to learn how to communicate with the younger folk, and it would be really interesting to get some more information about that. I believe that transcending adversity through stories is a very powerful medium.

Research tells us that being mentally unwell, say through depression, is very toxic to the brain. A brain that has been depressed for some time will find it harder to move out of that state, so, again, prevention is very much better than cure. Counsellors at Youth Focus try to help the young people to build up their resiliency, build on their strengths, learn prosocial ways of coping and talk problems out so that they can be worked through. Many of our clients would end up

having to access child and mental health services if they were not provided with the service that we have.

One of the difficulties that we have is that trying to grow the service is a challenge because from year to year we do not know what sort of funding we are going to be able to access, so that can be quite stalling. I guess we have to sing for our supper a little bit in our organisation. As Jenny has said, we do not have a lot of government funding, so we need to run our own events and go and talk to corporates. I do not believe, obviously, that the government should have to do all of this, and it is only right that the corporate sector and the community take some responsibility for providing funding, but we hear a lot in government about building capacity and things like that, and obviously that is very challenging in the not-for-profit sector if we do not have that support.

When young people tell me about their difficulties, one of the big areas that seems to impact on their wellbeing the most is the family unit—no surprises there. As we know, adolescence is a really tough time for kids and also for parents. We have found that families are at a loss as to how to communicate with their kids and how to break through. We have two family counsellors at the moment. Unfortunately, we do not have an outreach capacity for the family service, so families need to come to either Burswood or Joondalup to access that. So, again, I think more flexibility in the delivery model of services for families needs to be looked at. We have the luxury of a free service, obviously. We can provide long-term counselling. Some of our clients have been with us for a couple of years. We know that that is a luxury. Obviously government departments really cannot offer that level of service, but we feel that we need to take it even further and break down that barrier of families accessing the service by us going out to them in their communities. I was just listening to the speaker earlier, and I absolutely agree with the sense that each community needs its own approach to suicide prevention. There is not a one-size-fits-all model. Having project workers in each borough, in each area, to bring all the different services together would be absolutely fantastic.

Another thought is with regard to reporting in the media on this issue. We have all heard about the prevalence of copycat suicides. When someone completes a suicide, quite often there is a peak in the number of suicides occurring around that time. So I do understand why the media is nervous about addressing the issue of suicide, but not to talk about it at all, pretty much, I think only reinforces the belief that it is wrong to talk about suicide. It makes people feel like they are alone—and this is the information that I have been given from my clients. Reviewing policies with a view to creating some guidelines that protect people but also help organisations work with these issues would also help the media know what they can talk about and what they cannot talk about. I think at the moment it is very stigmatising.

When we go into schools at the present time, we cannot mention the word suicide and we certainly cannot talk about self-harm, even though that is what we really need to do, because there is a lot of fear around: ‘Gosh, you’re going to actually create it; you’re going to encourage people to go and try self-harm.’ But how can we break down those stigmas if we are not actually hitting it head on? I guess we as an agency are a bit unsure about what we should be doing, so some research around that and some guidelines would be really, really helpful.

We have a real shortage of male counsellors working in the helping professions. As a case in point, we have 15 counsellors at Youth Focus; we have one male. Obviously this puts a strain on

young guys coming in and wanting to speak to a male counsellor. That is not always possible. I do not know what we can do about this other than get out into schools and encourage young men to sign up for psychology and social science courses. I think the same thing goes for Aboriginal and Torres Strait Islander people. Since I have been at Youth Focus, in the last three years we have had lots of job opportunities come to the fore and we have not had one Indigenous person apply for the job, which is a real shame because, again, that stops Indigenous young folk, I believe, accessing our service, and there is a lot of work to be done in that area.

Young people, clients of mine, who have presented to the hospital system due to suicidal ideation or self-harming behaviour report to me that in some cases the experience is very punitive. Staff working in emergency departments and with self-harming young people, I feel, need to be trained more extensively in this area so that they can avoid compounding the problem by fostering more shame and guilt in the young person. Being punitive and telling a young person not to waste our time when they come in with self-harming injuries only leads to further isolation and stigma. If medical professions and those at the front line foster these kinds of prejudices and misconceptions, I ask what hope there is for young people accessing those services. I had a conversation with a nurse last week who was quite angry about the number of young people presenting to ER with self-harm, and she actually said to me that she sees it as attention-seeking behaviour. I thought, 'Gosh, how helpful is that to a young person coming in who is really struggling—to get that sort of attitude?' I believe that rigorous training that really challenges people's belief systems needs to happen to get that shift.

One of the themes that you are going to hear a lot about today is connectedness—'act, belong, commit'—and the belonging aspect of that. We believe very strongly at Youth Focus that this is a real way forward for people. There are a lot of young men, Aboriginals and Torres Strait Islanders and all sorts of people who simply are not going to go to an agency to have a conversation with a professional. What I believe needs to happen is that people need to be encouraged by their families, by schools and from all points of view to get involved in their communities and commit to things. People who are connected to their families, their friends and their communities are much less likely to suffer from mental health problems.

In the work that we do with young people, we are always looking for the barriers to connectedness and working to break those down, and the same applies to agencies and organisations working in this area. There are still many silos out there—people doing great work but still being an island in what they are doing. The movement right now, quite rightly, is towards collaboration and the joining up of services to create more of a net under the vulnerable. As Jenny mentioned briefly, we have a memorandum of understanding with Inspire Foundation and also with Lifeline Australia with the hope to create a triad of services from the phone counselling, the face-to-face counselling and the internet counselling to cover the bases, as it were. I think I will leave it there.

CHAIR—Thanks. Senator Furner, I know you have a time line, so do you want to ask any questions?

Senator FURNER—Yes, thank you, I appreciate that. I have a particular interest in the self-harming area. Your submission talks about—and this is the first question I would like to put you—the Beck Depression Inventory and Beck Anxiety Inventory supports. Can you just elaborate a little bit on what they are please?

Ms Marshall—Certainly. They are outcomes measures. Within the first three or four sessions of seeing a young person we will give them these measures to complete, which gives a score which indicates what their level of depression and anxiety may be. That allows us to review the counselling each three months or so or as necessary and, at the exit point, to assess our level of success in terms of supporting that young person. To be honest, it is an area that we are looking into further. We as an agency are not convinced that those are the best measures and the most appropriate for our client group. That is certainly an area of development that we are currently looking at. Other than providing us with a raw score and indicating whether someone may be in the clinical range and therefore needing a referral to a GP or CAMS it actually is a conversation tool—questions such as, 'When does that happen? When doesn't it happen?' It really allows us to thoroughly assess what is going on for that young person. You might be surprised by the fact that we give an anxiety inventory when we are looking at depression. We find that quite often the two go hand in hand. Where there is depression, quite often there is also anxiety—social anxieties and those kinds of things.

Senator FURNER—Do you find that in terms of the assessment that the youth are self-harming elsewhere on their body, which may not be able to be identified?

Ms Marshall—Absolutely. In most cases self-harming is a very private act. Most of the clients whom I work with self-harm on areas of the body that you would not necessarily see. They wear long shirts and things like that. Actually, a very small percentage kind of wear their scars with pride, if you like. That is why it is very difficult to find out who is doing it. It actually takes somebody to come forward and to say, 'I've been doing this for a couple of years.' It almost has an addictive quality to it. The medical model would say that if you are feeling a lot of emotional pain and you cut yourself you do have a release of endorphins so, on some level, it kind of works. But, as with anything, you kind of need more and more of it so, ultimately, you get more and more scars and you have to cut deeper and things like that. It is a tricky one, and there is a lot of shame involved. I do ask all my clients who are self-harming, 'Can I see your scars; I need to assess what's going on?' It is really difficult for them to actually show those scars.

Mrs Allen—Just jumping in there, I do not know whether anybody has mentioned but we are just starting to work at the hospital with Fiona Wood. One of the latest parts of self-harming is burning with wart medicine on the arms. She is having to replace skin because the burns are quite severe. It appears that, in a self-harming area, cutting is the most common but people always seem to be finding new ways and new things to do as far as how they self-harm, which is pretty disturbing. We are starting to work with the hospital there.

Senator FURNER—The previous witness spoke about the opportunities for research into schools. If you are not able to go into schools and talk about self-harming how do you cross that barrier of getting over that hurdle of identifying people and gathering that research yourself?

Ms Marshall—That is a very good question. In schools we try to talk about depression and mental health in the context of how it can make people do some very unusual things and we give some examples. We do not actually use the word 'self-harm', but I say that people engage in quite destructive behaviours—it could be drinking alcohol, driving fast cars, it could be related to pain and that kind of thing—to try to send out the message that we are aware it is going on and to please come forward.

Mrs Allen—We were just talking about that. We have just finished an event, the Hawaiian Ride for Youth, where we ride from Albany to Perth on bicycles, me in a car and them—44 of them—on bikes. We call in at nine schools on the way, so we do a whole lot on awareness and prevention. Interestingly, many of those schools do want you to talk about suicide prevention. Normally, two riders present at each school and they talk about why they are doing it and about their commitment et cetera. We have seen probably 1,500 kids in the last week. We just finished on Saturday night.

Another interesting thing is that during the November before we do this ride we actually visit those schools. We have a presence in them because of our south-west run that I just mentioned. I listened to the people before us as well—from the ministerial council—and each area has different problems, so we tried this year to pitch our speakers at those problems. Some of the schools in Albany are currently dealing with violence. Last year it was suicide in Albany and when we got there this year it was self-harm. I think they go through stages of the issues that we deal with on an everyday basis and they become more prevalent in school.

The other thing is respect. Younger women are taking photos of themselves topless and sending them to the 14-year-old boyfriend; then the whole school has them. There is absolute chaos around the place. It is a case of just dealing with respect for themselves and for each other. We have been able to do that, which I think is very much about prevention and really creating for them an awareness in those regional schools that people like us do exist and that they need to go forward and put up their hands and talk to people like us in their schools.

In that regard the counsellors cannot speak about it but, when we do an event like we have just done, often Mr and Mrs Average who ride—elite riders, I might add—are prepared to share their stories, because many of them ride immemorial of either people they have lost or someone they have known. It is really quite emotive. We take questions and the kids become really involved. Many of the schools will show our video before we get there and they include it in their curriculum. They might do an assignment on it before we ride into the schools.

CHAIR—Was that the video you showed us in Canberra or is there another one?

Mrs Allen—There is a new video out called *A Reason to Ride*, a documentary. If we show a video or they show a video we get them to look at it before they decide what they are going to do. Most of them do not show our videos but some do choose to, but they show it quite separately and then they have open forum discussion with their kids in whatever year.

Ms Marshall—The other thing to add is that we also have an advocacy service at Youth Focus so that people, school psychologists and parents do ring us and we can talk through ways to cope. We recommend that they be quite forthright and ask outright: are you self-harming? Sometimes it can be a relief.

Mrs Allen—I would like to reiterate what Nicky has said regarding the media. We as an organisation and you people as government need to address that matter, because we are still skirting around the edges of it. We are really not addressing it and media are still petrified to write anything because of the copycat instances. We cannot keep pushing it under the carpet, as we have done for so many years. It is still a huge stigma for people. If you talk to people who have been through it—for example, we have several mothers who ride with us who are

triathletes who have lost children—they are very definite that if they had known more they would have been much more helpful to their children.

Ms Marshall—I think that is the concept of personal stories and that is why we brought up that matter. I think that is the missing link. Rather than coming in and giving information, if people from the ground up are sharing their stories—teachers and parents—then we can break down that stigma without kind of saying, 'We're going to encourage it.' It is more real.

Senator FURNER—Should there be more of a campaign, similar to the bike campaign you do out there in our communities, similar to the one Senator Moore and me are actively involved in, which is Relay for Life for Queensland Cancer? A couple of times a year we get involved in raising awareness and we give donations to find cures and solutions. Do you think there should be a greater awareness through that sort of initiative as well?

Ms Marshall—To be honest, I think that can only go so far. We are coming from the point of view of young people. With a lot of that stuff, people say, 'Those oldies are going for a run again; they have no idea what they're doing,' so I wonder whether we need to make it more youth friendly and more appropriate to the individual communities themselves, whether it be Aboriginal people, young men or older people—whatever the risk factors are.

Mrs Allen—Also, the young men area is such a difficult area. As we have just said to you, to get male counsellors is almost as difficult as finding hen's teeth. It is terrible. I do not know what the answer to that is. The only way we counteract it is through our mentoring programs. Fortunately, we have a lot of men who train to be mentors and that helps us somewhat with our young boys. Otherwise, people have to deal each time with women and often they do come from only a female family with no role models in their life, so I think it also exacerbates the problems.

Senator ADAMS—Can you give me the names of the towns that you went to on this particular ride? I come from Kojonup.

Mrs Allen—We start in Albany and come through Denmark, Walpole, Pemberton, Busselton, Bunbury, Mandurah and Perth.

Senator ADAMS—The south-west. I was just wondering if you did the great southern loop.

Mrs Allen—No, the two people we have moving into Albany in our office will go out to Denmark and Mount Barker. We have not gone to Kojonup yet. It is difficult each time with how we are going to do it. I want to let you know that 40 per cent of our referral base does come through the schools. It is really again about funding. Paul Newman's foundation funded the office in Albany to start with and the ride has funded the rest. We then have to get the business community behind us.

We found Collie to be probably one of the most difficult towns to break into. We do not go riding in on our white horses anymore. We go in there and work with the other local agencies that are there and with the school. We normally work out of the school. We might be there a half day or a day. We sort of start in that way to get the community involved and then we bring the businesses behind that to make it sustainable. There is a lump sum to start with and then we have to be able to sustain it.

We found with regional communities that the worst thing is to go in and then take the service out. I experienced it the first time we went to Collie. Several of the agencies said they were moving out—one was the drug agency and I cannot think what the other was. People just say, 'They come and go.' That is never our intention. When we move somewhere we have to stay there.

Senator ADAMS—Are you working closely with the school chaplaincy programs?

Mrs Allen—Yes, we are. We just delivered at their conference last year. We are really just teaching and advising chaplains the things they should know and what they should be looking for to be able to liaise with us.

Ms Marshall—We developed a package called Attention on Prevention. It was a train the trainer model. We ran the program for the chaplains and then gave them the package to run in their schools.

Senator ADAMS—Would we be able to have a copy of that?

Ms Marshall—Absolutely.

Senator ADAMS—I think that would be very useful. Coming from a small community, I know just how important that chaplaincy fund is and the fundraising that is done to keep the person there. They are the conduit for all of these children who have a problem. They trust them. The teachers are too busy. That person is a member of the community, knows the families and has a really good idea about what is going on. Often they have children of their own.

Mrs Allen—It is essential they stay there.

Senator ADAMS—I have been asking about the use of the Internet and Facebook. Before communication was probably within the classroom and the school and not really as widespread as it is now. I will use the example of a student doing their TEE who is getting desperate and feels everything is going wrong. They feel so stressed they do not know what to do. If they put a comment on Facebook it goes everywhere. Do you have any sort of program for somebody who has got that message and realises that that kid needs help? Do you have any way of linking in there?

Ms Marshall—We just did some work with the town of Vic Park last month. Someone from Microsoft, the Federal Police and Youth Focus had a forum with parents and teachers and talked about cyberbullying and the safety parameters that are available that you could put on that. Certainly it is something all the counsellors bring up with young people—how to keep safe and that kind of thing. We do not actually have a program as such, but we are working very closely with Inspire, who are housed in our building, on trying to develop these programs. Young people are much more computer savvy than we are so it is trying to learn what they know and then come through with something helpful.

Senator ADAMS—There are drug awareness programs that say to look after your mate. If something happens and they are unconscious, the program tells them what to do. These people

are where? This person is obviously crying out for help. How do the people who receive that email deal with it?

Mrs Allen—That is why we have set that triangle up, because we are not a crisis centre. To have Lifeline as a crisis area and to have Inspire to back us up, especially in the regional areas, is really important, where our young people know about the Reach Out program. Eventually what we will be doing with Inspire, or one of the plans, is that several counsellors will man the Reach Out area at night because, as you know, it goes all over Australia.

Senator ADAMS—I have asked this question before of government people. Is there a program within schools for year 12 students and those sitting for TE on how to deal with stress?

Ms Marshall—There is some really good stuff happening in schools, but it is done on a bit of an ad hoc basis. There is not a blanket program going across to all year 12s. I was previously working as a school psych. Certainly in the goldfields and in Joondalup, where I was working, there were some fantastic stress management programs for students in years 11 and 12. A lot of them had been designed and put together by the staff in schools. They included meditation and relaxation and all that sort of stuff. It was really good work.

Senator ADAMS—Does the health department do any training of triage staff within our emergency departments here on helping self-harm people or mental health patients so that when they front up they do not get left sitting in a corner for four or five hours because it is all too hard?

Mrs Allen—I think it is ad hoc, again. Some do it very well and some not so well. I think PMH do it quite well. Some of the kids that we see obviously go there. In relation to self-harm, I think the punitive area is still very relevant in all the departments. I can only speak from my experience with one lass I was looking after, who sat for hours and hours. She needed stitching and all that sort of stuff and they left her, basically as a punishment. If you talk to people who have actually been in that situation, you find that it still happens and it still happens very regularly. It is almost like they have to punish them. I think they understand, but they do not accept that this person is crying out for help and, because of what they are doing, they do not need to be punished any more; they have punished themselves really.

CHAIR—I would question that understanding. If they are still treating people like that, I do not think they truly understand.

Senator ADAMS—We have heard so much evidence of exactly what you are talking about. How can we fix it here in Western Australia?

Mrs Allen—Again, I think it is education. It is about educating those people in ER departments. They would say that they are stressed and overworked and they do not have enough people and all those types of things, but I think there needs to be a program put in place about self-harm, because it is very relevant at the moment, especially in the target group we work with.

Senator ADAMS—In orientation, surely to goodness, when they train and go to work there, there must be something. I will probably bring it up with Kim Snowball, because we have had so much evidence about it, and see where that is going.

Ms Marshall—I would argue that everybody working on the front line with people who potentially have mental health difficulties should have mandatory training on that—and good training that really challenges and really gets in there, not just gives you a blanket bit of information and you kind of walk away go, 'Yeah, well.' It should be, 'Gosh, I have really seen things in a different light.' It has to be the right training.

Senator ADAMS—Some emergency departments have had a mental health trained person present on the roster. Is this happening?

Mrs Allen—That still happens, yes.

CHAIR—In all our emergency departments in WA?

Ms Marshall—Certainly PMH, which is the one that we deal with the most. If a young person presents to ER with suicidal thoughts there will always be a mental health person there to assess them and talk to them.

CHAIR—But you do not know about the other major hospitals?

Ms Marshall—No, mainly because, although we go up to 25, our target group does not go much above that. The person I was discussing was a 20-year-old girl.

CHAIR—Would the 20-year-old end up at PMH?

Mrs Allen—No, she was at RPH, at Royal Perth.

CHAIR—I know, from having responsibility for kids over 13, I would automatically take them to one of the bigger hospitals, not to PMH.

Mrs Allen—Up to the age of 16 they have them there.

CHAIR—But a lot of parents would take them straight to their nearest ER rather than going into PMH.

Mrs Allen—Yes, that is quite true.

Ms Marshall—There is a dedicated social worker at RPH for self-harm.

CHAIR—What about Joondalup?

Ms Marshall—I do not think there is one at Joondalup, not for self-harm. There is not one at PMH either specifically for self-harm.

Mrs Allen—The other thing I would like to mention is that we pull out a lot of data, a lot of statistics and we have a fairly good data system. Nobody uses it. Ministerial council—nobody uses it. We have never been asked for it. I have discussed that with them many times.

CHAIR—Even when they were developing the latest strategy?

Mrs Allen—Yes—never used it. I think a thousand kids is a fairly large number, plus 1,500 that we see and talk to, as I have just mentioned. Overall, we probably talk to close to 3,000 young people a year. It is a fairly good number.

Senator ADAMS—So what about the institute? They have not caught on?

Mrs Allen—No. And they do know us very much, but they do not use our data. So I make that point.

Senator ADAMS—Thank you; that is very valuable. They are talking about partnerships—I think you would be a pretty important part of that partnership.

Mrs Allen—I would think, from a metropolitan area, yes, very much so.

Senator ADAMS—Were you asked to go into Narrogin?

Mrs Allen—No, nothing. Just to clarify that, we would often be asked by schools in the metropolitan area if there is an issue that they might like us to go in and deal with. We have had a group of six kids that were going to commit suicide, so we have gone in and done some group work with them et cetera. In the country areas we probably do not get asked. We will now more so because of the spread we have in the south-west. For instance, I have just set up a visit by Julian Krieg, who you probably know, to one of the schools in Albany which is having difficulty with young boys and violence. He will perhaps do some seminars there. We can work in partnership with those sorts of people. Otherwise we would mainly get asked to help out in the metropolitan area if there is an issue.

Senator ADAMS—I asked because Narrogin just had that crisis with the school and all the problems there. I would have thought that, despite the fact that you are metropolitan based, they would have utilised you as a resource to go in and get it balanced up a bit.

CHAIR—I have one final question. Yesterday we were talking to Mission Australia and they gave us a copy of their national survey. We were all interested to look at some of the statistics that they highlighted around where young people seek their advice. The overwhelming majority of them said it was from their families. It varied. As people got older, fewer and fewer went to their families, and it also varied between gender. Is your data consistent with that—that, first off, young people would go to their families?

Ms Marshall—My experience is that it has probably been more to peers, because, again, we work with the adolescent age group, so they are moving away from mum and dad and attaching more to their peers. That is why we developed the peer support program, which is four camps a year where at-risk and socially isolated young people come away with us for 48 hours. It is a therapeutic camp but there is a balance of creative activities, sporting activities and group work, to connect them up really. It is fabulous to see that, at the end of it, they are swapping numbers and hooking up and all the rest of it. That is why we developed that program, because really that is where the work is done—educate the peers and get the strategies out there and they can pass them on to each other. That is our experience. Things might be changing.

CHAIR—That is why I asked. Certainly the evidence that we have had to date indicates that people were going to their peers or others rather than families. That is why I thought I would ask.

Mrs Allen—And so many families are broken.

CHAIR—Yes. Thank you very much. Your time is very much appreciated. We have given you a bit of homework. If you need any clarification on that, the secretariat will assist you.

Proceedings suspended from 10.55 am to 11.16 am

RAJAN, Mr Suresh, Executive Officer, Ethnic Communities Council of Western Australia

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

Mr Rajan—Yes.

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

Mr Rajan—This continues on from the previous speakers who were talking about some of the issues concerning data collection on suicide prevention. One of the questions I asked them as they left was: 'I understand you've got a very good database. Is there any ethnicity data relating to that?' And they said no. That there is no ethnicity data is one of the issues that we are confronting. In Western Australia, just under 29 per cent of the population were born overseas; about 49 per cent of the population were either born overseas or one parent was born overseas. So we are talking about a significant proportion of our population. But I guess we have not really captured any data to allow us to analyse whether there are some issues or trends that are being discerned, because we cannot get the data. We obviously cannot get the data from WA Police because suicide is not a crime, so they do not get involved in the issue of a suicide. The health department indicates that they do not keep ethnicity data either. So we do not have a sense of what the issues are.

Senator ADAMS—What about the coroner's office.

Mr Rajan—The coroner's office have indicated that they can extract the data; however, when it came to my writing the submission they wanted five or six weeks to get the information to me as it was not readily available. I would hope that they would keep data of that nature, but we are not aware of it. We did ask them, and I did not get past the front reception.

Senator ADAMS—We have the coroner coming in this afternoon. That is something that we could ask them.

Mr Rajan—Yes. It would be very interesting to see whether he can shed any light on whether or not there is ethnic data, given that we have numbers of people coming in from refugee backgrounds who are particularly survivors of torture and trauma. They have gone through some major mental health challenges to get here, and we are not really providing anything. There is one transcultural mental health service in Western Australia. We used to fund another one but that no longer exists. One service is run by the Multicultural Services Centre of Western Australia called MAITRI and it provides counselling, mental health advice and referral services in a bicultural, bilingual way. That is a very heavily accessed service. ASeTTS provide some services in relation to torture and trauma survivors; but, again, from my discussions with them, it appears that there is something close to a six-month waiting list for a person to get to see a bicultural counsellor of any kind.

Touching on some of the issues that were discussed earlier, such as bullying and so on, we are getting a few reports from different schools—again, this is anecdotal; we do not have any hard data—indicating that they are having some issues with people from refugee backgrounds, usually, and certain parts of Africa, that are forming groups. They are getting together and bullying others, and the other way around as well. There are some issues there that lead to challenges in mental health for some of those young people. Dealing with this on a much more global basis, you are looking at getting down to understanding what settlement services are required for some of the humanitarian entrants and ensuring that those settlement services are provided adequately; otherwise, they are going to end up with mental health issues that may result in high levels of suicide.

The main submission that we were working around was that we need to get some concrete ethnicity data on this so that we can start discerning any trends. Anecdotally, we can certainly say that we are seeing increasing reports of suicide amongst culturally and linguistically diverse, or CALD, communities. We are being made aware of a lot more. In the last three or four years we have seen more and more each year. We can point to individual instances where we can clearly indicate that the overwhelming control of your life can be related to either religious or cultural beliefs. This is what leads people to have different views of the value of their life. Anecdotally, we can point to a number of instances in recent years where we have seen that manifest in either an increased suicide rate or the methods by which they have undertaken the suicide. I am happy to share anecdotal examples with you, if you would like.

If you are looking at that, I can point to a doctor friend of mine who was born a Hindu, converted to Catholicism on the date of his marriage and in 36 years never went into a temple again. A month or so before he died, he went to Malaysia, where he originally came from. He asked to go to the temple on his way to his sister's house. He went there, said his prayers and came back to Perth a few weeks later. He contacted me and asked me to do various things in case something happened to him. That was on a Friday. On the Saturday and Sunday he did the same thing again—contacted me. On Monday he walked into a petrol station in Belmont, doused himself with fuel and dropped a match on himself. What he was doing was acting according to the Indian belief of self-immolation to remove your sins. So you can see that 30 years after giving up Hinduism it still was part of his life, part of his thinking and part of his culture. The way he undertook that suicide was so much based on that original culture and original religion.

We have seen a few of those. The issue of loss of face has manifested itself in probably three suicides in the last 12 months that I am aware of, among CALD communities. In touching on the settlement services aspect of it, I think one of the things that can lead to higher levels of concern amongst the CALD youth communities, and the refugee youth community in particular, is the fact that in Australia when people come into the country we place children in a classroom based on their age. Someone who is 15 and comes from the middle of the Sudan may have only had two years of schooling because the school was bombed. So they become the dunce of the class. They get no actualisation from the classroom. They look for it out in the streets and amongst like-minded people—people who come from a similar cultural background.

I think the mental health of children in CALD communities is a major issue that needs to be addressed. Some of them have endured enormous amounts of trauma and torture. Also, information from the Australian Institute of Criminology here in Western Australia indicates that the incarceration rate amongst the African communities is significantly increasing, so it

demonstrates some issues related to the mental health challenges particularly faced by CALD and humanitarian refugee entrants.

CHAIR—Are you okay if we go to questions now?

Mr Rajan—Absolutely.

Senator ADAMS—Mr Rajan, within your organisation have you got counsellors or a team that has been set up to deal with any of these issues?

Mr Rajan—We are not a service provider. We are an advocacy organisation. But we have affiliations with a number of service providers who do provide mental health services in a culturally appropriately way, and I would mention MAITRI as being the main one that does that. We do have access to that.

Senator ADAMS—So you have got a referral pattern if somebody does come. Would they come to you first? Do you think so?

Mr Rajan—This touches on something that the previous people were saying about who they go to for advice. My sense is that they would go to their tribal elders, so they would go to the tribal elders in the first instance. They would seek advice from the elders in the community before they would go to a formalised service.

Senator ADAMS—As far as rural areas go, I am think about Katanning being such a multicultural community. Do you have any communication with the people in Katanning?

Mr Rajan—Yes. We were actually significantly responsible for the resettling of a number of Burmese refugee families in Katanning. We went down there and spent a lot of time with the various service providers to make them aware of the cultural issues involved with that particular group of refugees. So, yes, we do have contact and regular discussions. We have consultations in the regional areas. We have done Katanning, Bunbury, Geraldton and Manjimup. In recent times we have been out there talking to all those communities.

Senator ADAMS—Are they settling down fairly well? Are there problems there?

Mr Rajan—The Burmese refugees are settling in exceptionally well. We were very careful, in the movement of those refugees to Katanning, to see that they were moving from rural to rural, so they were moving from a rural background in Burma to a rural background here. We tried to minimise the disruption factor by trying to make sure that there was only one settlement, so it was not Burma to Perth and then from Perth a few months later to Katanning but it was going straight through to Katanning. That is important. I think you cannot have dual disruption. As for the answer to your question about if the Burmese are settling in, they are settling in exceptionally well. It is a very tight-knit community. We have very strong and fairly tireless workers, who are champions for them, here in Perth who go down on a regular basis to make sure that they all settle in.

Senator MOORE—Mr Rajan, you made a number of points in your submission about communication and services; they all seem to fall into those areas. Is your organisation linked to

the new state suicide plan? We had information about the wide consultation and partnership basis of that plan. Was your group involved in that?

Mr Rajan—Yes. One of our committee members was certainly presenting. He is the executive director of the Multicultural Services Centre of WA, which provides some of the service areas. So, yes, he certainly had some input into that.

Senator MOORE—So from your understanding are the issues that you raised in your submission part of the discussions as to the new plan?

Mr Rajan—I would think so.

Senator MOORE—We had the ministerial council people talking to us. In their extraordinarily long submission they actually did mention some data by Kryios which was some attempt to look at estimating. They very clearly said this was an estimation process around what I think is quite a significant rate of suicide amongst people from non-English-speaking backgrounds. So it has been put on the agenda and what we do with it now is up to all of us, to make sure it works.

Mr Rajan—I gather that even in the National Suicide Prevention Strategy issues some of the multicultural community information was highlighted—that we need information about suicide data collection et cetera on an ethnicity basis. That raises a whole series of other issues as to how you identify ethnicity as well. People can identify as being African, as opposed to being Ugandan or Eritrean, so it raises a lot of different issues, because culturally people from South Africa are very different from those from Eritrea but they are just as much African as anybody else. Even within Indian communities people can identify different levels—state level as opposed to a national level—so there can be some enormous difficulties. How far down you want to drill is another issue—whether you need to drill down to that level of data or whether it is simply okay to get someone who is Indian as opposed to Gujarati or whatever it may be.

Senator MOORE—There seems to be an issue with people who use that only as a basis for other things. I have asked in other areas about their role of interpreter services, and you have mentioned specifically in your submission that a lot of the counselling and support for people and families is by phone. That is just the nature of the way the services operate.

Mr Rajan—Yes.

Senator MOORE—I asked in Victoria about that, and they said that they were relatively satisfied with the response of the interpreter service. They did not have their own; they used the state one. They said that it worked quite well. From your experience and from what people tell you—because I know you only gain information; you do not go beyond that—do you have any comment you want to put on record about the immediacy and effectiveness of interpreter services in quite a specialised area of counselling?

Mr Rajan—I certainly think that the language services that are available are inadequate. For example, NAATI does not have interpreters in certain languages because they are relatively new languages et cetera. There are four or five African languages that are not being picked up at the moment. We have had regular contact with the interpreters in this area. The difficulty in this area

is that you are getting into such a specialised field of counselling and psychiatry et cetera that you are really trying to translate something into a language that is very complex, even in English. On the other thing we have had some issue with in regard to the availability of information in languages: we were producing a DVD introducing people to the law of the land in Australia, and our first approach was to do it in English and then caption it in 12 languages but we discovered that most of the people accessing it are illiterate in their own language so they cannot read the caption. So we then have to find someone who can do a voice-over in that language. The medium by which we communicate this information to the CALD community is also very important. I think we need to understand that there are people with literacy difficulties in their own language and therefore we need to look at other media by which we can communicate.

There are consumer protection issues that go to this area as well. Again, anecdotally we are seeing lots and lots of African community children who are finding themselves with incredibly difficult mobile phone contracts and getting themselves into debt which they do not want to be in and then contemplating suicide. You cannot just look at an issue and say: 'How do we communicate these things?' We have to look at it as almost every agency being responsible to ensure the mental health of the individual. How do you do that? By all sorts of different ways of communicating messages. The area of stigma reduction is another big area. I think that the recognition of mental health challenges is an issue. Depression is an issue—and the understanding of it. I never heard the word 'Alzheimer's' until I came to Australia. We referred to at as 'dotage'—'He's in his dotage. Don't worry about it; he forgets things.' Recognition that mental health is an illness, a challenge, and not a stigma to be borne by the family, is a big issue amongst a lot of CALD communities.

Senator MOORE—There are places and people to help.

Mr Rajan—That is right.

Senator MOORE—And then it gets into a circle—if you are offering that, it has got to be there.

Mr Rajan—Yes.

Senator ADAMS—We have had quite a lot of evidence on triage at emergency departments, especially in the area of self harm. Have you had any complaints or any problems in that area?

Mr Rajan—I cannot say we have had any complaints. I suspect that, if mental health issues were displayed by members of the CALD community at an emergency department, they would probably be missed. I think the triage people would not be sufficiently trained on cultural issues to try and pick up signals of any kind. So I would think that any issues there would be missed. I am speaking without any real issues or complaints having been brought to our attention.

Senator ADAMS—What about interpreter services at emergency departments?

Mr Rajan—I do a number of cross-cultural awareness training programs for a few government departments and, without a shadow of a doubt, in every agency where I have delivered that cultural awareness training program the people receiving the training have not

been aware that they are not to use a child under the age of 18 as an interpreter. So, in other words, the interpreter services are quite inadequate and in many instances health issues are being discussed with children under the age of 18 because they happen to be there. There is a statewide language services policy that indicates that you are not to use a child under the age of 18 under any circumstances, including emergencies—

Senator MOORE—And everyone ignores it.

Mr Rajan—Yes, everyone promptly ignores it.

CHAIR—They would want to use any method of communication that they can and it would be an automatic response. I am not justifying it; I am just pointing that out.

Mr Rajan—That is right. Just think that you could be discussing a father's sexual health issues with a girl under the age of 15. It is very hard to handle that.

CHAIR—I wanted to go back to the issue of data. When we had the ministerial council here, they said that when they were preparing the last strategy they asked the coroner for data and they were given cold cases and information on 5,000 people from 1986 onwards.

Mr Rajan—From 1986 to now?

Senator MOORE—1986 to 2006.

CHAIR—It was a 20-year time frame.

Mr Rajan—Can I put that in context? What were the total number of suicides in that time?

CHAIR—We did not then break it down. They were given 5,000 cases to look at and we did not break it down in that conversation. There is more data in the strategy. I was just wondering whether you have had any conversations with the ministerial council or its predecessor around the breakdown of that data.

Mr Rajan—No, we have not. I would be interested to get some of the data. Have they updated it since 2006?

CHAIR—No, not that I am aware of, and the data that they were using, which Senator Moore was talking about earlier, around the number of suicides in immigrant communities and the percentage with non-English-speaking backgrounds relies a lot on overseas data. They are looking into that a bit more, but I was just wondering whether there had been interaction between you when the strategy was being developed using the data that they had managed to get from the coroner.

Senator MOORE—The coroner determined that from 1982 to 2006 a total of 4,787 deaths in Western Australia occurred as a result of suicide.

Mr Rajan—That is the total?

Senator MOORE—Yes, 3,840 men and 947 women.

Mr Rajan—That is over the period of—

Senator MOORE—1982-2006.

CHAIR—That is interesting because they said it was 1986 data.

Mr Rajan—It is a 24-year period and there are about 5,000 suicide deaths—in total, not just CALD communities.

CHAIR—That is the total, but I was wondering whether you had had discussions with them about—you know when you were talking earlier about data.

Mr Rajan—Yes. We have not had that discussion with them. I would probably need to have the discussion around that.

CHAIR—We will ask the coroner because the recording of ethnicity may be—

Mr Rajan—Problematic.

CHAIR—Yes. We have had that discussion with coroners in other states around whether somebody was Aboriginal and Torres Strait Islander or non-Aboriginal and Torres Strait Islander. There are problems around recording that level of data, let alone then going down to African and where they come from in Africa.

The other issue I am keen on following up is the issue you were talking about of mental health for children because, particularly with refugees, it is highly likely that they would have been exposed to a significant amount of trauma. It sounds like there are not that many services for addressing mental health issues for children in CALD communities.

Mr Rajan—I do not think there are any; I am not aware of any that address children specifically. Certainly the MAITRI offers children some services. I think that recognition, even within CALD communities, by parents of their children's mental health issues could be a problem. I do not think most of my humanitarian community members would fully appreciate what their children are going through, what they have gone through and what they are suffering from. I think a massive education program needs to be conducted at all levels with the CALD communities to make them aware of some of the signals that may be sent. Imagine that someone has come here after seven, eight, 18 years in a refugee camp where none of that was an issue; none of that was even considered to be something that would be looked at.

I want to touch quickly on this issue of mental health. I think one area that we have also fallen down on very badly is that we had some discussions with the Indian community around what is happening with Indian students around Australia. We felt that there was a necessity for subsided or free mental health services to be provided to international students. We are dealing with 500,000 international students in Australia: 106,000 of them from India and 110,000 from China. These are people who have come from rural and remote Haryana and Punjab in India to urban Perth and they are away from home. They are suffering all of the mental health issues of being

lonely et cetera, and we have got one person in the immigration centre who is there because he is at pathological risk of suicide. He has tried to commit suicide three times. He is an Indian student. His visa has been cancelled.

CHAIR—Because of that?

Mr Rajan—No, his visa was cancelled because he overworked. So his visa has been cancelled and, under normal circumstances, Immigration would let him out into the community to wind up his things before he goes away but they have had to take him into detention because he is at risk—he has tried to commit suicide three times. Someone needs to attend to the mental health issues that have driven him to that point, but he cannot access any of the services that we provide to permanent residents of Australia because he is a temporary resident, so 457 visa holders are temporary residents. Why should they not be entitled to some subsidised mental health access?

We have got six instances of 457 women who have had domestic violence perpetrated against them. If they leave the marriage they will be deported because they have no status in this country. Why? They are paying taxes like the rest of us. I guess the availability of subsidised mental health care should be available. We are talking 500,000 international students who should be allowed access to that. It is a $17 billion industry that we have made a lot of money from, but we have not given them a lot. We have got some Indian students who have tried to commit suicide—a couple in Melbourne and a couple here.

CHAIR—What sort of support are they getting from outside the government sector?

Mr Rajan—They get a little bit of counselling from the institutions that they attend, but that would certainly be very inadequate. I do not think that there are high levels of counselling available at most of the institutions. I am not certain that it is an issue with the tertiary sector, but it is a huge issue with the vocational education sector.

CHAIR—That is what we were just commenting on. The universities would provide more services probably but there would not be many in the small institutions.

Mr Rajan—That is right. The small institutions have exploited the industry completely and they are not providing any of the pastoral care and services that are required. As I said to an Indian student the other day, 'What are you studying?' He said, 'Holistic medicine,' and I said, 'Let me get this right in my mind: you have got a system of Ayurveda in India that is 5,000 years old and you come here to study that? You may as well have stayed home.' So, yes, services need to be provided there.

CHAIR—In terms of the work of your advocacy organisation, how far are you getting with advocating to get better mental health services for the broader CALD community and particularly for kids?

Mr Rajan—I think I might give you a completely wrong impression of the level at which we are funded in terms of our advocacy. We are not getting very far because, basically, the council is funded to the tune of $100,000 a year—that is total funding.

Senator MOORE—State funding—

Mr Rajan—Yes, we do not get any federal funding. It is difficult to try to push these things forward. Since Dr Gallop's departure as Premier, we have not seen the commitment to multiculturalism and service provision in the CALD communities that we did see in the past. We have not seen any commitment really to multiculturalism and the provision of services in a culturally and linguistically appropriate way. We have not seen a strong commitment from any government since Dr Gallop, so that is a difficulty.

CHAIR—The new strategy seems to say pretty good stuff overall—

Mr Rajan—Yes.

CHAIR—Are you engaged in any discussions with the ministerial council, or the Telethon Institute for Child Health Research that have now got the successful tender, in terms of getting more services for the CALD community under the strategy?

Mr Rajan—We have not been, and with the Telethon institute I will certainly rectify that fairly quickly and go to them and talk to them about some of the things that we should be doing.

Senator MOORE—Concerning the issue raised about students and people with 457s—it is definitely a national thing?

Mr Rajan—Yes.

Senator MOORE—Do you know whether the national body has raised this formally with the government?

Mr Rajan—As in our national body, the Federation of Ethnic Communities Councils?

Senator MOORE—Yes.

Mr Rajan—I do not think so. We have put together a discussion paper around Indian students in particular with some of those issues that have come up, and that is in the final process of being submitted to Andrew Metcalfe from Immigration. We will refer it to Laurie Ferguson and also Senator Evans—

Senator MOORE—It has not come before us before, but it is incredibly important and when you state it we think, yes, it is certainly important. So we will have a look at taking that one forward as well, because it is a much wider issue in terms of the international students and 457 people who are away from home and do not have access to services. It is critical and I had not considered it before.

Mr Rajan—Generally, government services have been restricted to people who are permanent residents. You do not have to be a citizen but you do have to be a permanent resident. Unfortunately, 457s are temporary residents and students are temporary residents and—

Senator MOORE—A Senate community affairs committee took up the issue of people in detention and it was a direct focus of that committee, but the wider issue was not taken up as strongly as it should have been. It is important that you raise that.

Mr Rajan—Thank you.

CHAIR—Thank you very much. Your time in coming to present to us and your submission are very much appreciated, and thank you for waiting.

[11.50 am]

BUTT, Dr Julia Carol Morton, Senior Research Fellow, National Drug Research Institute, Curtin University of Technology

STEARNE, Ms Annalee Elizabeth, Indigenous Australian Research Associate, Indigenous Australian Research Program, National Drug Research Institute, Curtin University of Technology

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

Dr Butt—Yes.

CHAIR—We have your submission. I invite either or both of you to make an opening statement and then we will ask you some questions.

Ms Stearne—We acknowledge that we are representing a team, which includes Professor Dennis Gray, Associate Professor Edward Wilkes and Dr Mandy Wilson.

Dr Butt—As we are representing the Indigenous team, we will mostly talk today about Aboriginal and Torres Strait Islander suicide. We are a national centre and so most of our experience comes from around Australia, but we can certainly talk about WA, if need be. As we are from the National Drug Research Institute, our focus is mostly on the role of alcohol and other drugs in suicide. This is a very complex and multiply determined issue and there are many regional variabilities. When we sat down and thought about the most important points that we wanted to bring to you today, it was quite difficult. We have a few that we would like to emphasise here, particularly in the role of research—we feel that it needs improvement—and also in service delivery and service coordination.

In terms of unmet need in research, we would very much like a more dedicated approach to funding in the alcohol and other drug sector in order to look at the role of alcohol and other drugs in suicide. We know anecdotally that it plays a very important role as both a perpetuating and predisposing factor in suicide attempts, completed suicides, parasuicidal behaviour, self-harm and other associated behaviours.

We also recognise that in this area a lot of things are swayed by anecdotal evidence, and so there is a real need to collect more solid data. There are a couple of areas where that is particularly important. One of them is in impulsive suicide attempts. We know that the majority of services and policies in Australia are pretty much directed towards suicide which follows a pattern of being premeditated to a certain extent. In the Indigenous community and certainly in other sectors of Australian society, impulsive suicide becomes a much greater risk, and that is often in the context of alcohol and other drug use. It is much more difficult to predict; it is much more difficult to respond to. Because it comes out of the blue, it is also very difficult for communities to come together afterwards and to move forward. So I think there is a real need to spend some time focusing on impulsivity.

Another area that is in need of more research is that of contagion and cluster effects. We are now also looking at echo clusters, which is the idea that a cluster of suicides might occur in a particular region. Given the mobility of a lot of people, you might find that six months or 12 months down the track a very similar cluster appears in a nearby community. We need to do a lot more research, and that way we can inform service delivery, coordination and policy approaches in that area. When we are doing that, we also need to recognise—and a few people have mentioned this already today—the issue of missing data. I will leave Anna to explain that.

Ms Stearne—My experience comes from a lot of work that I have done with a couple of the communities in Central Australia. The evaluation of one of the organisations there highlighted the need for recording attempts and also the difference between an attempt and a threat and what is a real threat. In evaluating a program, you measure the effectiveness of that program, but this is difficult when no-one is responsible for recording that sort of information and, therefore, the data is coming only from that organisation. So we tried to triangulate it. At the same time, no-one is willing to take that sort of responsibility. When you look at a lot of communities, you think, 'There are no suicides here,' but the number of threats is sometimes five or six a night.

Dr Butt—And, again, that is often in the context of alcohol and other drug use. Previously, I worked clinically in Brisbane for a community controlled health organisation, particularly with paint and petrol sniffing young people. We were involved in the aftermath of a lot of attempted suicides. There is nowhere to record that. If the police are not called and there is no way to immediately get someone into a medical facility, no-one will record it. To witness these events—attempted hangings, to cut someone down from an attempted hanging, which is what a lot of people have had to experience—obviously leads to ongoing trauma and stress. We do not have any data around that and, as Anna said, there is no methodology either, or responsibility.

In terms of intervention and service delivery, I could probably talk all day about that, so I will have to try to shrink it. The major areas are obviously prevention, intervention and postvention, or following up after a suicide or a suicide attempt. We want to emphasise the need of whole-of-community approaches to this, particularly when we are looking at distinct communities in regional and remote areas. Often a workforce is very lacking in these areas. The particular areas that we feel need more investment include workforce development—for example, the recognition of the role of Aboriginal health workers. They are often available 24/7. They are not paid for that. They are often not provided supervision. In a non-research capacity as a clinical psychologist, I have supervision and I need supervision to maintain my registration. That is a security blanket. That is not there for Aboriginal health workers. Nobody is there providing supervision and support and that level of pastoral care. It is assumed that these Aboriginal health workers can manage a huge amount of responsibility, yet they are not provided training or support and they are certainly not provided the after-hours availability funding for the level of work that they do.

We would also like to emphasise the importance of community control and multi-level interventions—the 'no wrong door approach'. There is a need to have people trained in a range of services, particularly alcohol and drug and mental health, to react to suicidality and suicidal behaviour and to also help communities with what I refer to—and it is probably a bit of a strange term—mental health literacy. This is speaking about what mental health issues are, knowing the language that service providers use and also providing communities with realistic expectations.

I have had personal experience of being in small communities where people say to me: 'Oh, you're a psychologist. You need to talk to these people because they have got trouble.' I am there for one day on a completely different matter but there is this word and someone has oversold the profession or someone has oversold counselling to think that a one-off consultation might actually help. Our need to upskill and capacity build within communities to manage some of the matters internally is a big issue.

Alongside that, obviously, is the recognition of the multiple levels of trauma and stress, which leads back into the contagion effects, which often reduce to copycat suicides. We would encourage you not to see it as that. They are probably a lot more than copycat suicides. It is another level of stress; it is another level of trauma. The more research that we do on physiology, the more we know about the effects of stress. You add into that impulsivity and alcohol and drug use and if you have been brought up in a situation of trauma your ability to tolerate distress and to manage that overwhelming physiological response is diminished, so the likelihood of suicide is obviously a lot greater.

Finally, I introduce the thought of dual diagnosis. We need to improve the capacity of mental health agencies to work with alcohol and drug clients. Alongside that is the recognition that—and this is certainly not an Aboriginal or Torres Strait Islander issue only—a lot of mental health issues in young people and males will not necessarily involve acting inwards and being depressed. They can involve acting out. Typically, in child and youth mental health services there can be the decision to not accept someone as a mental health client or as having a diagnosable condition when their behaviour is externalising. They will end up within the corrections services, and the corrections services become the default mental health agency. In the Aboriginal community, that has had a lot of negative consequences, with behaviour being seen as behaviour and not as a mental health problem.

Just quickly, I want to mention postvention. We would really like to emphasise for postvention policies to be in place in all agencies and also within communities. Often they are ad hoc. If there is an attempt, suddenly everyone is scrambling around and two weeks later you get a psychiatrist—someone you have never seen before who flies in once. Why you would talk to them, I do not know. I feel this as well in terms of general medical and health services. You need a postvention policy or your staff will burn out. Obviously, there are reporting requirements. But there are huge impacts there.

Ms Stearne—I want to support a lot of what Julia was talking about, particularly with the community control issue and the need for it. Above all, we need coordination of care through all the services. A lot of services exist. You have drug and alcohol programs that work, and they are doing a little bit of this. But there is no coordination between services, particularly in remote communities. In some cases, I have heard stories of 20 service providers flying in to a remote community where none of them know each other or what the others are doing. They all arrive the same day and they all leave the same day. Particularly in regional and remote areas, the communities are really asking for coordination. But the services do not have the capacity in terms of what they are expected to do to coordinate that. It is often a secondary or tertiary role for them. The coordination service needs to be funded, as well as the capacity in those communities to manage that.

Dr Butt—There is certainly a need for positions to be dedicated to service coordination. That is what the experiences of community members shows. You can end up in a town where someone says to you, very politely: 'And who are you with? Which one are you?' Because services get defunded and funding cycles are so short, you disappear within two weeks anyway, so why anyone would talk to you I am not sure. The key point of what some of what Anna is saying is that without a person whose job it is to coordinate it is not going to happen, because if you have workers there on the ground the chances are that they want to see clients; they do not want to be coordinating services. I have sat in meetings with a lot of well-intentioned people whose workloads get the better of them, and there will never be another service coordination meeting or email group or whatever. They are lovely as an idea, but there is no position to follow through on them.

Ms Stearne—I just want to highlight something. It is still embargoed, but we recently finished a report for the National Indigenous Drug and Alcohol Committee, which is the Indigenous committee of the Australia National Council on Drugs. In that, we mapped all the Indigenous specific drug and alcohol services that operated during 2006-07. It is due for release—

CHAIR—That couldn't have been easy to do.

Ms Stearne—No, it was not. The report is called *Indigenous specific alcohol and other drug interventions: continuities, changes and areas of greatest need*. It is about Indigenous specific drug and alcohol services. That gives a snapshot of what was happening at the time and what the gaps are. There are quite a few recommendations within that that might link into mental health issues.

CHAIR—When is that going to be released?

Ms Stearne—On 13 or 14 April.

CHAIR—Do you want to table that and we can undertake not to release it before it is released—is that what you wanted to do or would you rather forward it to us later?

Dr Butt—Or just let you go and find it.

Senator MOORE—We could make a note and we can seek it after 15, and that is going to the national group which is auspiced by health and ageing.

Ms Stearne—Yes.

Senator MOORE—Warren Snowdon has now got the responsibility for that under Indigenous health.

Dr Butt—Ted is the chair but he did not do the research.

CHAIR—But that is the body that he is the chair of.

Dr Butt—Yes, it is.

CHAIR—Do you want to keep that so that there is—

Senator MOORE—no likelihood of it going. I think it is best you keep it; I really do.

CHAIR—If we write down the details and then we will get a copy of it after it is released. Then it does not get messy because anything that is tabled people have access to. Is that okay with you?

Ms Stearne—Yes, that is fine.

CHAIR—Are you okay if we go on to questions?

Senator ADAMS—You have been sitting here listening to our last witness and the questions. What has come up quite often has been the accident and emergency area and the triage system. Have you got any evidence of problems that people presenting with a dual diagnosis—for a start—have of actually being seen, especially if they have self-harmed?

Dr Butt—Obviously, there are two different contexts. Firstly, within an urban area there is somewhere to go for an accident and an emergency. Erratic, chaotic behaviour and dishevelled appearance, which is common to a severe mental health condition, does not lead to prompt service in my experience of taking clients through that process.

I guess there is a great difficulty in the sense that police end up being the front line in mental health whether we want them to be or not. Ultimately, they have to be called when things get heated. I have certainly called them but I am aware that, given the history and the relationship between the police and certain areas of the Aboriginal community, they are not going to call the police. Again, this leads back into us not knowing how many attempts are there.

In terms of the police responding to suicides, which is in some senses necessary, those relationships need to be strengthened a lot more before that becomes a functional pathway. Similarly, the capacity—and I am speaking from personal experience of one quite negative experience involving ambulance officers assisting with an attempted suicide. They had obviously not been trained to deal with people around them who were quite intoxicated and they became very angry and agitated at the other kids who were sitting around watching what was going on. It was just a very negative experience. Legally, they had to take this kid away because he had made this attempt. He needed to be assessed in hospital, but the way the whole process went no-one wanted to do it again. No-one was going to call the ambulance next time someone looked like they were getting hurt.

My experience is: you do get seen. It ends up happening. It is very easy to lie your way out and say, 'No. No. No, I won't do it. I was just doing this and that.' But often the process is so punitive that people who are at risk and at need do not go back.

Ms Stearne—In general, there is an issue with hospital data. In some states whether someone is Indigenous or not is just not recorded and not reliable. As Julie was saying, in remote regions there is not going to be a response often. In one community I am thinking of the representatives of the community organisation, not even the health service, are the ones who respond. It might

be two weeks before somebody comes out. The immediate response is quite limited and therefore the data is limited.

Senator ADAMS—Have your research papers looked at the training for these frontline people, whether they be police officers, school teachers or health workers? I am perhaps thinking more about somebody going from the city out to a remote community and the work that is done on what they might have to cope with. Is there any research on that? Because there seems that there is definitely a breakdown somewhere. It is in the city emergency departments as well. How can we fix that?

Dr Butt—In all honesty I do not think there is a hell of a lot of research into that at all. What we are talking about is implementation. I think there are a lot of wonderful plans out there but they are not well implemented, and the consultation process with respect to bringing those plans in, and the staff in, is not always well executed. I think sometimes the practice of sending very young females into communities to do youth work without a proper understanding of the different relationships between men and women is a problem. Reputations get destroyed very quickly through inappropriate behaviour, where people quite simply have not been properly trained. It becomes a very difficult decision for someone who is managing a remote health or counselling service, who has to ask, 'Do we want someone who is not the best candidate for the job or do we leave the position vacant?' It is a really tough call to make. At the moment there is no research or evaluation of programs. From our perspective there is often an evaluation of a program, recommendations are made and we can see a great way forward but it does not get re-funded and someone else will start from scratch. You will have heard everywhere about continuity of funding, but a lot of it comes back to that—if the job security is there, people will stay. But if you have community members that you have trained up, rather than bringing the people in, you are going to have a better workforce.

Senator ADAMS—I would agree with that. It just worries me that the actual understanding of these frontline people could be made so much better for everyone, whether it be the client or the person who is having to deal with the issue. Somewhere we have to fix that gap. That is why I asked the question about the research—because you are dealing with the situation all over Australia whereas we are only scratching the surface.

Dr Butt—I was dealing mostly with cannabis and was doing a trial at a particular medical service in South Australia. We did some training and six months later we came back to see how some of the changes had gone, and the staff turnover was 50 to 60 per cent. So the sustainability of training needs to be there; it cannot be a one-off. If you are parachuting in trainers, it is great for a week.

CHAIR—Parachuting trainers into an organisation, into a community?

Dr Butt—Yes.

Senator ADAMS—Have you done any work with petrol sniffing?

Dr Butt—I personally have, yes.

Senator ADAMS—Whereabouts was that?

Dr Butt—I was working with Queensland Health at the time and worked from Brisbane up through Mount Isa, Cairns and Townsville.

Senator ADAMS—Do you see through your research that the use of drugs is increasing in remote communities—or the combination of drugs?

Dr Butt—There is no concrete evidence where we can say, 'This is actually what the research says.' Every community is different.

Ms Stearne—Yes, there is so much regional variability.

Dr Butt—Without a doubt cannabis is increasing. We have good quality data that shows that in the broader Australian community over the last 10 years the use of cannabis has declined but it has increased five-or 10-fold—I cannot remember which—in Indigenous communities.

CHAIR—Do you have an evidence base for why that is, or anecdotal reasons?

Dr Butt—Anecdotally you could find someone who would tell you anything. But probably road quality has a huge amount to do with it. We have seen trafficking and police seizures of cannabis right up the central corridor from Adelaide through to Darwin and in the Cape.

Senator ADAMS—Mintabie.

CHAIR—Yes, Mintabie. When you said that yesterday we were trying to think of where. This committee travels a lot and we are also all on the Regional and Remote Indigenous Communities committee, so we have been doing a lot of work in that area.

Dr Butt—Yes, there was a big seizure in Mintabie about two weeks ago.

CHAIR—I knew it was a place starting with 'M'! We have heard a lot about Mintabie.

Dr Butt—There is a lot more and it is becoming quite easy to buy. It is like with anything when market forces apply.

CHAIR—We were told yesterday up around Broome as well, some of the communities there.

Dr Butt—So it is very prolific. In the area I am working on at the moment it has been around the fact that it is often seen as the lesser of two evils, particularly in the white community, 'Oh, it's only ganja,' so that message has been used by health services.

Ms Stearne—The work I have done on petrol sniffing has involved evaluating the Comgas scheme and how to improve policing responses to petrol sniffing. When we were talking there, and this is five years ago, they were asking us, 'But isn't ganja better, because it does not have the same sort of social impacts—

CHAIR—At first.

Ms Stearne—Yes, at first. The store is not destroyed immediately and people are sleeping rather than causing humbug in the community.

Senator MOORE—There is no good thing, but in terms of the immediate brain damage petrol is worse. How do you actually size up what is the lesser of evils? You can understand the police saying the impact of ice—

Dr Butt—I have heard Queensland cops going, 'Dammit, we took our foot off the pedal on it because we pursued heroin and now we have got problems.'

CHAIR—We have heard in some of the other communities as well.

Senator MOORE—And particularly the North Queensland police.

Dr Butt—Yes. They have big trouble there.

CHAIR—Sorry, we sort of took over there.

Senator MOORE—It always happens when we get to drugs.

Senator ADAMS—You go on and I will think about what I am going to ask.

Senator MOORE—You have covered most things with what you have said and the submission. One thing that has been brought to attention a couple of times today and certainly by the group who represented Aboriginal and Islander psychologists is the workload and the workforce issues, which I think are critical, and also link between that and funding, which is the overwhelming issue. There does seem to be a real need to train lots of people, including people who are Aboriginal and Islander, into these professions, because it is not the first choice. I am not sure whether it is actually promoted as it needs to be in high school. When people are working so hard to keep kids in school anyway, it is looking at what comes next. I understand that the relatively recently formed Aboriginal and Islander psychologists group are seeing that as one of these big things, which is fantastic. But consistently we hear that even when programs are funded, and that is tough enough anyway, it is almost impossible to get the workforce. Your statement about do you get anyone or no-one is critical. I am not sure of the answer except increase focus on workforce and encouragement and all those things, but it is also the effect of mentoring from people who are already in the profession so that people are not feeling isolated. You have already touched on it but to me it is overwhelming. I wonder if you have got any ideas.

Ms Stearne—One of the biggest factors in terms of workforce relates to services provided by non-government services, and what people are paid there is just not competing with government services. People who are qualified, particularly Aboriginal and Torres Strait Islander people who are qualified, there is just no comparison. The number of people I know who are very good in their job who have moved to working for the government just because it is $30,000 or $40,000 more—

Senator MOORE—Plus superannuation plus conditions.

Ms Stearne—And job security. NGOs cannot compete with that.

Dr Butt—It is a huge issue and there are so many different points at which you can start looking at it. The university experience and how that is managed is improving on most campuses. There is a commitment by most campuses now to have facilities for Aboriginal and Torres Strait Islander students. I think they are still not great. I have concerns, and it is terrible because I am obviously a young female, about people who have not had a lot of experience with the level of poverty and the level of trauma to which they will be exposed going into communities and they are not able to cope. If there were stronger people going into those areas they would be able to do some other training as well and some of that sharing of the workload. So I think we could have alternative models of getting through some of these degrees.

Half of psychology is maths. If you want to help people, you do not necessarily want to learn maths for three years. Some of us are nerds and we do it anyway, but it is about getting through that and providing alternative options. I know some insanely intelligent people who, halfway through a degree, become very popular to an employer and are offered a job: are you going to be a student, are you going to go to work? You are going to go to work and you are never going to finish that degree. I have seen that quite a few times—it breaks my heart.

More alternative models of getting through the intensive degrees of medicine, psychology or social work and more mentorship would be positive. The recent moves by the Australian Psychological Society have been positive but they have been a very long time coming. It will be interesting to see the inroads they are able to make over the next five years.

Senator MOORE—At the moment there is certainly more funding around but if we go through the process of training people and beguiling them into this form of employment, as opposed to something else, and then there is no work, it is then a double betrayal.

Dr Butt—Yes, or into not well-remunerated work. It has been hard for me as a clinician to do a five-day clinical week, but I do not go home and have people contact me and need me. So having more flexible working arrangements will enable people to have longer leave in recognition of the fact that they do so much work, that that work is so close and that there is an impact on their own mental health and longevity in a profession. Concerning training opportunities, Anna and I—particularly Anna—have been involved in organising a lot of conferences. You get pretty good presentations from a range of Aboriginal agencies, but they cannot come to the conference because no-one is going to fund them. You have probably talked about this but everything is more expensive when you are coming in from somewhere else and the money is just not there either to bring people in to train or to take good people out to do the training.

Senator MOORE—The acknowledgement in the funding base as well is critical.

Dr Butt—Yes.

Senator MOORE—Your submission already talked about the horror of the short-term funding cycle and what that does to people in terms of programming and planning. You can see the fixation we have had on your booklet—and that talks about our wellness—and I have a question in terms of process. Putting that together took more than eight phone calls?

Ms Stearne—Yes. It took probably nine or 10 months worth of telephone calls. It was a matter of getting information from government agencies and government departments, which took three to four months alone.

Dr Butt—How many people were making the phone calls?

Ms Stearne—At one point we had six doing telephone calls and there were a lot of issues and barriers within that. The services did not have the capacity to respond to us either. I can remember ringing and ringing one service and he goes—I just could not do it.

Senator MOORE—He could not get back to you.

Ms Stearne—This was post the Northern Territory Emergency Response so people were very nervous as well.

Senator MOORE—You went in for all the right reasons.

Ms Stearne—Exactly. I was based in Alice Springs at the time.

Senator MOORE—With workforce from across the country leaving other agencies denuded.

Ms Stearne—Yes.

Senator MOORE—The reason I asked that question—which was extraordinarily stupid when you think about it—was to get on record that to get an audit of every funded organisation providing these services in the community was not a matter in the state and federal funding agency already having that list.

Ms Stearne—Yes. Actually, them having the list was probably one of the biggest problems, barriers.

Senator MOORE—I would imagine that now you have done that work—I did quickly read at the start that there was previous work done and you acknowledge that in the forward.

Ms Stearne—Yes. It is a very similar report to one we did for the ANCD for the 1999-2000 period—I think it was a report No. 4.

Senator MOORE—In comparison, this is another enormous workload: what was happening then, where they were and who they were, which I know you could never get, in terms of what is happening now with some expectation that, once this is there, people will be able to use this as a benchmark and, say, keep their own records. So that the Queensland government, for their sins, will have a list of all the agencies operating in a network—that kind of thing is the hope.

Ms Stearne—You would hope so. The original report came out of a database that we had online that became too labour-intensive because people were ringing us up and saying, for example: 'I want to start up a night patrol. What other night patrols are operating?'

Senator MOORE—Which would be a simple question, you would reckon.

Ms Stearne—Yes.

Senator ADAMS—Not at all here.

Ms Stearne—Yes. We did it in 1999-2000. I was involved in maintaining that database and that is where the report came from. We already had the contacts in the organisations, and then it became too labour-intensive. For one person it was at least a six-month full-time job alone, without doing anything else—just contacting organisations and funding organisations. And people move on, so it was about trying to maintain the relationships. So we did not have that existing start. So when it came to doing this one we actually had a lot more work to do. In that time, prior to actually finishing, I was contacted by at least three different individuals in government departments who did not have any corporate knowledge and were looking for what used to happen here, what was funded here. Something like that would be great. It would require probably one person, maybe two people part time, to just maintain that sort of thing. But it would be great to have a government department actually be able to provide that easily.

Senator MOORE—Your organisation would get a range of funding, some of it projects based, some of it linked to the university—do you get something from the uni?

Dr Butt—Not a lot.

Ms Stearne—We are contract staff funded directly under the National Drug Strategy. It just happens that we come under the university and we get a little bit of funding from them, but we are fairly independent.

Senator MOORE—It would seem that, for that particular focus, specifically on Indigenous drug and alcohol services, someone should get dedicated funding to maintain that database. It should not be on top of everything else. It would seem that in some ways your organisation, which is independent, would be an appropriate place to do it, as long as you are appropriately funded. It is actually on a biannual basis that you would do it, so it would seem that might be something—

Dr Butt—That would be great.

Ms Stearne—We have already got the database system. It is in a database now, so it is just a matter of updating it. I designed the database. We already know what the pitfalls would be.

Senator MOORE—If you were run over by a truck, would the database be able to be used by other people?

Ms Stearne—Yes.

Senator MOORE—That is not just a personal comment to you; I ask that question all the time because that is the kind of thing that can happen, particularly considering the information you have had about the turnover, which is extraordinary in just about every organisation. So the database is now there; it is just a matter of maintaining it—it is not just a matter of that; it is a core thing. When you see the number of organisations you have listed there, it is a big issue to

keep it and have the credibility with those organisations so that they know it is trustworthy and it is not to be used politically.

Ms Stearne—Yes.

Senator MOORE—I think that is a good thing. Around the 15th we will be watching to see how that is promoted and launched and so forth.

Dr Butt—I believe it is being released at the Redfern ALS.

Ms Stearne—Yes. I think Warren Snowdon is going to be there.

CHAIR—There are a whole range of issues that we could chase up. We could be talking all day. On the issue around the unmet need for research and the involvement of drugs and alcohol in ideation, it seems to me that needs to be a key area of research that we should be focusing some attention on. What would you suggest is the best way of going about that—funding the institute who is doing that? I am just pre-empting that one! We had Darryl Kickett in here yesterday. We had ICCWA in here. We were talking to the Injury Control Council about their resilience project. One of the first things that I think Darryl mentioned was the link with drugs. He did not talk so much about the impulsive suicides but he certainly talked about the very close association between drugs and ideation. He also mentioned ice going into Narrogin, in particular, but I have heard about it in other areas as well. If you were writing our report, what would be the best recommendation? How should we frame a recommendation on this particular issue?

Dr Butt—Any research needs to be done within a partnership model. I can only speak for the National Drug Research Institute in a sense, but the model with which it operates is always to promote a collaborative partnership with a community, so there is a capacity building and collaborative arrangement. I think any model that is looked at to address this needs to include that. It needs to include a range of methodologies. We need to be doing qualitative research to actually find out people's stories and get out there and see what is going on. But also, in relation to the missing data that Anna talked about, we need to start to collect more data on attempts and to find ways of doing that.

CHAIR—My next question was going to be: how we do that?

Dr Butt—There is the coroner type data as well. There have been toxicology reports released about the levels of alcohol and drugs, but I am also talking in terms of a psychological autopsy leading up to the level of alcohol and drug use. And I would then like to go the full spectrum and also consider alcohol and drug use in distinct communities or in family groups after a suicide or suicide attempt. We know that it is a predisposing factor. Does that increase or decrease after a suicide? So there are a range of different issues there.

CHAIR—The Aboriginal psychologists association in their submission very clearly talked about a higher rate of contagion in Aboriginal communities as opposed to non-Aboriginal communities, so there is the link there with drugs and alcohol, and there are already issues around contagion. We have Alastair Hope coming in this afternoon, so we will be following up all these issues with him. The issue of recording attempts or threats is obviously one we need to pick up in the report, but have you given any thought to what methodology you could use?

Ms Stearne—I am just thinking of the particular community I was talking to, where I was also evaluating their program. They document everything, from when a child was told, 'No, you can't come into the disco because you've been making trouble,' and that child then said, 'Well, I'm going to go kill myself,' through to the proper attempts. They could not define it.

CHAIR—Who does it in that community? Is it an organisation or an individual?

Ms Stearne—That community is a Central Australian community that has a substance misuse youth development organisation. They are tracking it themselves, but we were trying to triangulate the data by speaking to the police and the health centre about how they had recorded it. They only record attempts which involve them being called out.

CHAIR—There would be a lot of attempts where they are not called out.

Ms Stearne—Exactly. The youth development organisation are the ones who get called out. They are there and they are the ones they call at two in the morning.

Dr Butt—It is a pretty hefty project to even come up with a methodology. Just sitting here trying to put some of the pieces together, I think it would be about selecting communities in different areas and looking at urban areas because most Aboriginal people in Australia live in an urban area. It would also be about contacting the agencies that are engaged with people and finding out the best way to start tracking this data. That would be from night patrols and youth patrols as well as from school teachers. It would be a lot of work.

CHAIR—First you would have to have conversations with the community about who is doing what in community, what the community is like and what are its structures.

Dr Butt—Yes. I certainly think it is needed, particularly having a look at the impact of alcohol and drugs.

CHAIR—We have gone over time again, but I have a final question. We were talking about training earlier. Does Curtin still do the block training for people in Aboriginal communities?

Ms Stearne—Yes, the Centre for Aboriginal Studies does a block release course in Aboriginal health and Indigenous community management and development.

CHAIR—They are still running those?

Ms Stearne—Yes.

CHAIR—A number of people have said to me they thought that was an effective program.

Dr Butt—It is a good model, a block release; it works well.

CHAIR—Thank you very much for your time. It is much appreciated.

Proceedings suspended from 12.35 pm to 1.27 am

SCOTT, Ms Michelle Silvia, Commissioner, Commission for Children and Young People

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

Ms Scott—Yes, I have.

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

Ms Scott—Thank you very much for the opportunity to appear before you today. For those of you I have not met before, I am Western Australia's first Commissioner for Children and Young People. I took up my appointment in December 2007. My functions and the principles under which I conduct all my activities are set out in the Commissioner for Children and Young People Act which was passed in the Western Australian parliament in 2006. I have a very broad mandate, which is to promote policies, laws, services and programs that enhance the wellbeing of all children and young people under the age of 18. There are currently 500,000 young people under the age of 18.

I must also give priority to Aboriginal children and young people. There are about 26,000 in Western Australia. They comprise about 44 per cent of the Aboriginal population, whereas children and young people who are not Aboriginal comprise about 25 per cent of our total population. I also must give priority to other children who might be vulnerable or disadvantaged.

Since I took up my appointment in December 2007 I have travelled extensively. This has helped inform me in terms of the priorities which I have taken as commissioner because, as you could appreciate, everything to do with children and young people is a huge agenda. Travelling throughout the state has been of great assistance to me, to meet with children; with young people; with their families; and with service providers, both within the government and the not-for-profit sector. It is in that capacity as commissioner that I appear before you today.

Firstly, I would like to say that I am not an expert in suicide. However, the mental health and the mental wellbeing of children and young people has been a priority of mine. I have provided to you today a copy of an issues paper, which my office released late last year. It gives some of the context for some of the comments that I would like to make today. If I could draw your attention to the mental health facts that one in six children and young people have a mental health problem; that 25 per cent of parents and carers think their child needs special help for emotional problems; that Aboriginal children and young people are at a significantly higher risk of mental health problems; and that in the area of mental health Australian children rank 13, out of 23 OECD countries, and that Aboriginal children rank 23 out of 24 countries.

In Western Australia we have had a significant increase in population of young people, but particularly in birth rates. So, since 2002, we have had a 35 per cent increase in births, and services in Western Australia have failed to keep up with that growth. There are significant early intervention services such as child health nurses, child development workers who assess learning difficulties and also physical difficulties such as speech impediments and so forth. There are

significant delays in parents accessing those services here in Perth in the metropolitan area. We have had three parliamentary inquiries at the state level that have found significant shortcomings in terms of early intervention, health services for children and their families. In some cases, families are waiting 12 to 18 months for an assessment.

In terms of mental health services specifically, mental health services also have failed to keep pace with the growing population and the birth rate. Everywhere I have travelled throughout the state, families and service providers have raised with me the lack of access to appropriate mental health services. You would be aware that in some regions in Western Australia not only is there a lack of services but in some cases they are non-existent. For example, in the whole of the Kimberley there is not one child health psychologist employed by mental health services yet, when you travel to any number of communities in the Kimberley, families and service providers will talk to you about the enormous needs that children have. If I could talk about some of those communities: Fitzroy, Halls Creek, where alcohol restrictions are in place—and I have supported those in response to particularly families and women calling for greater safety for themselves and for their children. I have been to Fitzroy on two occasions, the most recent visit was before Christmas, and every service provider in Fitzroy—including the police, the school, welfare agencies and the Women's Resource Centre—raised with me the serious concerns they have about mental health services for children in Fitzroy. I understand that there is a child and adolescent mental health social worker, just by accident, working in Fitzroy because her partner works at the school. Everywhere I went people said they needed 10 of that person to meet the needs of Fitzroy. There are incredibly significant challenges, even in the really small community of Fitzroy.

One of the points I have made as commissioner is that even though you might introduce, as a community and with government support, alcohol restrictions, you need a whole range of services that come behind that, including parenting programs, alcohol and rehabilitation services, and early childhood services such as good quality child care and playgroups. You also need strong mental health services. That is by way of example. In the metropolitan area there are highly variable services. Last week I was in Northam and Merredin. Although those wheat belt communities have given a priority to mental health services with their resource allocation, they told me of the significant delays in children and their families accessing mental health services.

I do not want to labour the point too much about other services, but I would like to report to the committee that, everywhere I go, people call for more parenting programs, and that is critical to healthy parents. Every mental health worker calls for more parenting programs. When we look at issues like suicide or mental health, it is very important to see that it is multifaceted and those early intervention services and programs and policies which strengthen families strengthen the mental health wellbeing of children.

Senator ADAMS—I am sorry I was a little bit delayed in getting back for your opening statement. The three of us in this committee are very familiar with Fitzroy because we are also members of the Select Committee on Regional and Remote Indigenous Communities, so we have had quite a lot of involvement with the community. Do you report back on these issues to government? Could you give us an example of your reporting process and, when you have identified all those issues, how you can get government attention? That is probably the best way to put it.

Ms Scott—I use a whole range of means to try to influence policy and practice and legislation. Mental health is a priority for me. We have done a number of things in that area. Firstly, I have produced two annual reports to the West Australian parliament. I do not report to a minister; I report to a parliamentary committee, a joint house standing committee. I have raised the issue of mental health and some of the things that I have talked with you about in my two annual reports. I meet regularly with my committee and I also meet regularly with ministers. I have met with the state Minister for Health.

I have welcomed the development here in Western Australia. Members are probably aware that mental health has been a part of the health department and the state government has recently announced the Mental Health Commission, which will be separate. I have supported that because I think it is very important that mental health gets its due priority, and I think the establishment of a mental health commission will do that. What I have said though is that it is very important that children and young people are given a priority within the new Mental Health Commission. I have met with the acting commissioner to discuss strategies and ways in which we might take that forward and work together.

If you talk to people working in mental health services in Western Australia, it becomes very clear that children and young people have not been given a priority, not just across the board but particular groups, and I have identified Aboriginal children and young people. The Telethon Institute for Child Health Research identified in the late nineties through their Aboriginal health survey the significant problems that Aboriginal children were facing in relation to their mental health. There are also children in the care of the CEO of the Department for Child Protection. We have about 3,000 children in care. They require significant mental health supports. Children in juvenile detention also require significant supports. There is no dedicated, forensic mental health service for children in Western Australia. Those children have very complex needs. Children living in situations of family violence, where alcohol is an issue and where a parent may also have a mental illness, have special needs in relation to their mental health as well.

To date, to answer your question, I have raised these issues. I am looking to strengthen my partnership with the Mental Health Commission now that it is being established to see what further initiatives we can take to ensure that children are given a priority in this area.

Senator ADAMS—Do you have an involvement with schools?

Ms Scott—I do. I visit schools regularly. I also meet with the minister for education and the director-general. Visiting schools is a great source of information. Recently I was in Northam Primary School, which has a 51 per cent Aboriginal population. The staff talked with me about some of the significant issues, including mental health, that some of those children are facing.

Senator MOORE—Ms Scott, we will be speaking with the coroner next. One of the things that has come out is the way that stats are maintained across the states. As you would expect, they are not coordinated, which is an issue as well. I come from Queensland, and they have done particular work with the statistics on young people who have committed suicide. I am wondering whether you are aware of any similar work in WA and whether, talking with your counterpart in Queensland, there has been any interaction about the methodologies and the reasons for doing that.

Ms Scott—No, there has not been. I meet reasonably regularly with the commissioner in Queensland, and the commissioners generally are meeting and cooperating on a number of issues. I am not aware of that work which the Queensland commissioner has undertaken, but thank you for that information.

I have highlighted that here in WA we do not report on a whole range of indicators in relation to children and young people. We do not have comprehensive data—or we may have it, but it is invisible. So one of the initiatives that I have proposed here for the early years of a child's life is that we, firstly, have a plan about what we want to do, so we have an early years plan, and that we also develop a monitoring framework, based on the Victorian model, with a number of indicators. That also would include mental wellbeing but not necessarily suicide. I have recommended that we report on a regular basis, every two years, on how children are faring in Western Australia. It is along the same lines as what you are suggesting, except that your proposal is in relation to suicide. I think it is very worthwhile. There is a lot of information in government agencies, but it is not presented in a holistic, integrated way so that the public policymakers can make good use of it.

Senator MOORE—The Ethnic Communities Council gave evidence earlier today and made specific reference to what they consider to be issues for young people who have come here from areas of turmoil, through the asylum process or through the assisted migration process. The representative commented on the fact that there are special needs there which may not have been identified effectively. In particular, they concern victims of trauma and young people who have issues with language and fitting into an education system which is focused on your age rather than your capability. In your work, have you had any particular issue with young people who have come through those processes?

Ms Scott—Yes, definitely. At the primary school level we have two initiatives here in Western Australia, at two schools, as part of an integrated service model. I visited those two schools, Parkwood and Koondoola. One is in the northern suburbs and one is in the southern suburbs. That is at the primary school level, where a significant number of children have come from other countries, through a variety of means. This model is all about bringing allied services onto the school site so that families can be more fully supported. They had an evaluation of that model and that evaluation showed how successful the model is.

I am a great supporter of integrated service models, particularly for disadvantaged families but all families are asking for them so you have one place that you can go to get the help that you need. School are a good, natural hub in the community for that. Notwithstanding that good model, there are particular challenges that those communities face in coming to Australia around interacting with government agencies and seeking out help. They have particular vulnerability. Those issues have been raised with me—issues such as their fear of going to an authority and their fear of seeking help. Also, where parents are extremely traumatised they might not recognise the needs of the children in the family context. So there are serious issues.

More recently, in some of the schools that I have travelled to people have raised with me an age-old issue. They go into the class, but they might not speak one word of English going into year 10 or year 11. This is particularly an issue for holders of 457 visas. Children are just placed in a school environment without any additional supports.

CHAIR—What was raised was the literacy and numeracy levels as well.

Ms Scott—Having said that, some of the schools that I have been to that have children from refugee backgrounds—such as Balga Senior High School, which used to be predominantly Aboriginal—are about an 85 per CALD community now. That is a significant difference.

CHAIR—A large African community.

Ms Scott—A large African community. They are so committed to education and want to learn. They see education as critical to them entering the Australian community. The teachers all report how the kids do not want to go to morning tea, have a break or go on their holidays. They get really disappointed because they love school and want to be part of the school community. That is on the positive side: they are ready to engage with school. But it is concerning that there are particular issues around their needs.

On mental health issues, at one country school that I was at recently which had some of these kids in it as well they were saying that they had a psychologist there for half a day a week trying to attend to everybody's needs. One of the themes, no doubt, that you are picking up and I pick up as commissioner all the time is, while we might have some resources in mental health, in schools and in other agencies, how they all work together effectively to achieve the outcome that is desired—in this case, the mental health of children. We have a long way to go at the state and Commonwealth level in that respect.

CHAIR—I have a range of questions that I would like to ask. One in particular is around Mission Australia. Presumably you are aware of their survey?

Ms Scott—Yes.

CHAIR—Yesterday, they were pulling out some of the relevant statistics for us. One of us was where young people seek their advice from. I must admit that we were all quite surprised that the survey said that most young people seek advice first from their family. It varied with gender and as young people got older that happened less. That was very different to (a) evidence that we had had previously and (b) some that we have further had today. What is your response to that?

Ms Scott—I last year commissioned a major piece of work. For the first time in Western Australia, we have asked children and young people about these things—and the successful tenderers asked about 1,000 young people throughout the whole state, including kids who are pretty vulnerable, such as some Aboriginal kids in Fitzroy and Derby, kids in care and kids with disabilities. I hope to publish that research report in the middle of this year.

The preliminary findings are interesting. They sort of fit with what Mission Australia is saying. Kids say, and they say this to me in all the schools that I go to whenever they meet me, how important their parents and their family are to them. That is even with families where things are not going so well. It was interesting to note in Fitzroy some of the kids' responses about this, that they often would turn to someone in their family. The second most significant group is their friends. That may change with age as well. I think those are two very important sources of information. Inspire and headspace are doing an outstanding job with very welcome initiatives.

Earlier this year I went to meet with the young people involved with headspace. While we have surveys and so forth, I think it is really important that we keep talking to children and young people about any program that we are designing as to who they would go to to seek out information. I think that is an ongoing dialogue with children and young people about what would work for them and what does not work for them. It was interesting with headspace that sometimes the kids did not want to talk. When they are a little bit older they do not want to talk to their parents. They actually want someone else outside of that situation.

CHAIR—As they get older they shift from parents to peers and the internet. When you look at the breakdown at the data, you note that as they get older a high proportion move over to getting advice from the internet.

Ms Scott—That is why having good information on the internet is a good idea. Kids also say to me they still like the personal approach. They do want a person to talk to, which is interesting. We did an exercise with kids and young people about complaints systems. Do they ever complain about a government agency or another agency? How would they like to see complaints systems operate? How could they be more accessible and responsive? It was interesting that kids said, 'When I want to complain I want to talk to someone. Even if it is at the end of the phone I do not want an automated answering machine'—and we don't either! They want a human being there. So they might get certain information from the internet, for example, but they also want to have person-to-person contact.

CHAIR—I have an issue that I have been chasing by asking questions of several witnesses. You mentioned kids in state care. I am also particularly interested in kids in kinship care or out-of-home care and specific situations around kinship care but I presume they apply to other forms of care as well. It is where kids who have been in out-of-home care have gone into kinship care and where they have been exposed previously, for example—and this is the reason they were taken into care—to abuse. They have long-term needs. It seems to me, and I know this from some examples, that kids are not getting the follow-up care that they need. You are taking kids out of the home environment and if you know those kids you can virtually guarantee those kids are going to have some sort of need for counselling and long-term support. It does not seem to me—in fact, I know the system is not doing this, because I know from experience that the system is not—that the system is following up those kids. I have asked this question in New South Wales, where they have actually got a project underway at the moment where they are starting to look at how those kids are progressing, the long-term needs of those children and the support they are getting. In Western Australia is any work being done on that? In a couple of years down the track those kids will not be getting support, for example. We know they are going to need support. What can we put in place? Where is the thinking at on giving those kids and their families and carers some support?

Ms Scott—I think there are probably a number of answers. The first is that our legislation which governs kids in care—

CHAIR—In state care?

Ms Scott—Yes, state care—so when they are under the care of the CEO. But they could still be living with a family or they could be in a not-for-profit arrangement, a foster care arrangement, or in a state-run facility. So there are a whole range of options. But they still could

be under the care of the CEO of the Department for Child Protection. If you look at the legislation which governs that, it will say that every child has to have a care plan and every child should have a leaving care plan. In Western Australia, we have quite progressive legislation which enables the CEO to provide support beyond 18. So your care and protection order might expire at 18 but up to the age of 25 the CEO of the Department for Child Protection can make available certain things, including counselling or financial assistance for counselling. So the legislation is there that enables that, through all the various planning mechanisms that should be in place. I think on the ground it is a totally different experience.

Prior to taking up this position as commissioner, I was the Public Advocate for Western Australia and my role was in relation to people with a decision-making disability—so people who might have had a mental illness or a cognitive disability, Alzheimer's or an intellectual disability—and I could be appointed their legal guardian once they turned 18. In that role, I was being appointed for some young children who were extremely traumatised because they had been abused and taken into care and subsequently abused and who needed a whole range of long-term supports that were not provided. So I have had experience of that on the ground. I think we need to do a lot more. I am not aware of the New South Wales example but it sounds like a very fine initiative.

There is another thing which relates to that which has, I suppose, two aspects. One is that kids in care often have behavioural challenges, and the support that they need to manage those behaviours is considerable. I am concerned that we do not have sufficient investment for those kids. Also, there is one other related issue I want to raise: when I was in Fitzroy, for example, the workers said to me that it is not just the kids who need help but the workers. You were talking about families as well as foster families. But—and I think we have discussed FASD—that is what teachers say to me, desperately: 'We want more help so that we know how to manage that child's behaviour or meet their needs in the school environment.' So I think there is a lot more that we need to do to equip the professionals to work with children who have these special needs as well.

CHAIR—Before I go on to my next area, there is another category of kids and those are the kids who are in kinship care, who have been adopted or are not necessarily under the care of the CEO. Are those kids still covered by that legislation?

Ms Scott—You would have to be under the care of the CEO.

CHAIR—Well, there is a group of kids who have gone into kinship care—they are not in the care of the CEO but they are still in kinship care—and have come out of very traumatic situations but are not getting that follow-up care. You can virtually guarantee that if they have suffered trauma they are going to need ongoing counselling and ongoing support. I know of a situation where there is tremendous need for ongoing support that was not provided because they are seen to have been adopted by someone and there is no ongoing support. I do not know the numbers but I suggest that, for Aboriginal communities, for example, there will be a significantly higher proportion of Aboriginal kids who would be in that situation, whether formally or informally. And, as I said, there is no support that I can see for those children. Is anything being done about that group of kids?

Ms Scott—Not that I am aware of, but I am not going to say that I am an expert in that area. So, no, not that I am aware of. But there may be some initiative that the Department for Child Protection has undertaken that I am not aware of.

CHAIR—Not that I have found so far. How involved were you in the development of the new suicide prevention strategy?

Ms Scott—I was not involved. Some of that work probably pre-dated my appointment. I am aware of the national and the state strategies, but that is really the degree of my involvement. I have not had any other involvement in that.

CHAIR—The tender has now been awarded to the Telethon institute, which seems to me to provide an ideal opportunity, particularly for the focus on children.

Ms Scott—It does.

CHAIR—Have you been engaged with them in the implementation of the strategy to date, or do you expect to be?

Ms Scott—I have not been to date. I am meeting with Fiona Stanley shortly, and we regularly keep up to date. Because my office is so small, I have to be clear about which areas I get involved in, particularly around implementation. I would certainly welcome a discussion with the Telethon institute, and I would then make a decision about whether or not I needed to be involved.

CHAIR—And, if it was travelling okay, you could just—

Ms Scott—Yes, exactly. Senator, you were commenting on children in care or in kinship arrangements and how they have tremendous mental health needs. That is absolutely true. I think the other thing that is missed around trauma and mental health issues is the link with the juvenile justice system and juvenile detention. Recently I met with the Create Foundation, a national organisation involved in supporting children in care. We talked particularly about what happens to kids who leave care. About 30 per cent of males who leave care end up in the juvenile justice system. When I was Public Advocate I saw some of those children—by the time they turned 18, they were well and truly linked with the criminal justice system because they had huge behavioural and mental health issues.

CHAIR—We ran out of time with some of our previous witnesses when we were talking about self-harm. I want to ask a few more questions about that in a minute. The other side of self-harm seems to me to be other behavioural issues around trauma and mental illness. It is not just physical self-harm; they can display other behaviours, and I suspect some of those are what cause them to end up having contact with the justice system.

Ms Scott—Yes, that could be right.

CHAIR—I am not sure if that is recognised in the same way as self-harm. We have heard of the stigma around self-harm and how people have been treated by emergency departments, for example—they are almost punished. We have had quite a lot of evidence around that. Although

people are now picking up on the self-harm side of things, I wonder whether there is enough focus on the behavioural responses that children display which lead to them having contact with the justice system.

Ms Scott—I suspect not. I think you were taking evidence from the coroner.

CHAIR—Just in the room behind you.

Ms Scott—He has more expert evidence to give in relation to that. My comment as commissioner would be around the risk-taking behaviour that children, particularly vulnerable children such as children in care and children in Aboriginal communities, participate in. Drinking alcohol and driving or getting into vehicles and those sorts of things are risk-taking behaviour, which is very detrimental to them. But I do not think it is often recognised as self-harm in the context that you are talking about.

CHAIR—On self-harm, we have had quite a lot of evidence, both in the east and here today, about the response by some of the agencies delivering services—for example, EDs where an injury is obviously a case of self-harm and they have been made to wait for quite a long time and treated quite roughly. Queensland received evidence of people not being given anaesthetic when they were getting stitches in an attempt to punish them. Have you had any contact with that or instances of where that is happening in Western Australia with young people?

Ms Scott—No—and nothing has been reported to me. I am not saying it is not happening but it has not been reported to me.

Senator ADAMS—I would like to come back to the role of the chaplaincy program in schools and what communication you have in that respect.

Ms Scott—The schools I have visited have indicated to me the important role the chaplains are playing. However, at the last school I was at, they were talking about how there had been cutbacks in, I think, the federal funding program. In one community in the region they were saying that the chaplain obviously works more than he is paid for but that he was playing a critical role in the community. Obviously there are some good chaplains and there are perhaps some who do not work quite as well, but they have been highly valued in the schools I have been in in terms of being another resource that kids can go to to talk about issues. It seems that, generally, it is a very good program.

Senator MOORE—The funding cycle is under discussion but the scare campaign about the cut has actually led to more trauma. It is under review at the moment at the national level. I will follow up on that question. I am also interested in the role of psychologists in the schools. My understanding is that Western Australia has a good system but there is by no means a psychologist to every school. In your experience, is the role of psychologists in the schools been considered? Have you visited schools that have them?

Ms Scott—Yes, I have visited schools that have them. My comment is the one I made a little while ago: firstly, about their relationships with other mental health practitioners and some demarcation disputes about what they are prepared to handle versus a mental health practitioner.

Some of the school psychologists have a more limited training, so that impacts on their capacity to service the needs in their school community.

Senator MOORE—It is applicable to chaplains as well.

Ms Scott—Yes. I think that we need more supports such as psychologists in schools. I think, though, that they need really good links with the external agencies.

Senator MOORE—Absolutely.

CHAIR—Having grown up a son through the West Australian public school system and having had some exposure to the issues around bullying, we had access, I must say, to excellent services through the school system. However, we had to wait months and months to get access to it but, once we were in, our son got really good support and, as parents, we got really good support. We had a fairly good understanding of how to access services, yet we did not know which door to go through. It was not until we made enough fuss at school that we were told where to go et cetera. Information was not provided to every parent. It was only when you knew to ask and then you had a hassle.

Senator MOORE—You had to kick up a fuss.

CHAIR—You had to kick up a fuss. I suggest that there a lot of parents in the system who do not know how to do that. They do not know that services are available and have to wait quite a long time to access the services. I would suggest that that can put quite a lot of people off.

Ms Scott—I agree with that. Parents say to me that they do not know where to go for a whole range of services for their children, whether it is mental health services, parenting information or developmental delay information. It is a minefield for them in the community. That is one of the reasons why I have promoted a one-stop shop where parents can come and get information and where all the agencies work together so you do not have to go off to education and you do not have to go off to health et cetera. They have some of those models in other states; we do not have that here in Western Australia. I think that is a good model.

The kids from headspace said to me that their parents sometimes did not take them seriously about what was going on with them and did not accept that they may have something a bit more serious than normal adolescence. A number of them made that point to me. That could be a stigma about having a child with a mental illness—perhaps the parents did not want one. A number of children involved with headspace raised that with me. They wanted to be taken seriously when they had concerns about their emotional wellbeing. They did not necessarily know where to go. That was one thing.

The other thing is the research I referred to before about children's and young people's views of their own wellbeing. One of the other things that are coming up is personal safety and bullying. I am surprised at that. We will have to analyse that information a bit more. Kids are very conscious of being excluded in a school environment in particular, and that can have enormous consequences.

CHAIR—From my personal experience, we knew something was going on with my son but getting him to tell us was quite difficult. He did not want to be marked out from the crowd as being bullied.

Ms Scott—Yes, it is very complex. I think that in Western Australia the education department has been doing a lot more work in this area and in the schools, and I think that that is a big improvement. We have some outstanding research. There is Donna Cross from Edith Cowan University and the Telethon institute. Bullying is also becoming a very big issue in Aboriginal communities. There is a research project in Geraldton where they are looking at that. There is texting and cyberbullying as well. We are lucky to have both of those researchers doing that work. I think that is one area where the public education system has responded quite well.

Kids have a pretty good definition of what bullying is now. It is not at the extreme end, which it was when I was growing up. It is if someone is doing something to exclude you and you do not feel comfortable about it. That was an interesting thing to come up in our research.

CHAIR—So they recognise it much earlier.

Ms Scott—Yes, and it is being talked about in schools as not acceptable. I think that that is good.

CHAIR—It also happens at a very young age. I was quite shocked at how early it starts at school. You think it is older kids, but it is not.

Senator ADAMS—To come back to the use of the internet and problems associated with that, something we were discussing earlier was Facebook. Especially with year 12 students, a cry for help goes out that someone is really distressed and has suicidal thoughts. In a normal situation before the internet, it would only be around people in the class or a few people, but now the fact is that it can go so wide. I asked about what programs were out there for someone who picked up this message and realised that this was serious. How could they deal with it, where could they go or what links could they use to help that person?

Ms Scott—My caveat is that I am not an expert in that area; however, Inspire were talking to me about the whole broad issue of the internet and educating young people about some of those issues and also their own safety on the internet. I think that, given their excellent outreach website and their involvement with young people, they would have more ideas than I about influencing and giving good information. Their website is fantastic. You will have seen it. It has sections for parents, for young people and for people who have been told something. It is a great resource, but for kids who do not access that there needs to be other ways of communicating in schools. What do you do when this sort of issue arises? What concerns me is the public nature of someone putting something on the internet. There is amongst young people themselves a lack of awareness of how it is out there forever.

Senator ADAMS—There is a stigma associated with it. Their names are there. That could lead to other nasty sorts of things happening.

Ms Scott—That is right.

Senator ADAMS—That was one of the reasons the chaplaincy program, with the internet associated with it, is so important to rural areas. Often the chaplains have reported back to me that this has been a problem. That was what I was following up; I was seeing if you had any indication of that through your office.

Ms Scott—Only what Inspire have told me. There is one issue at the regional level that relates to that. I was in a Wheatbelt town recently and kids were asking me: 'If you're a little bit different, where do you go? Everyone knows who you are.' The same was for seeking help as well. In a very small community everyone knows your business, who you are related to et cetera, so I think there are some particular challenges in those communities.

CHAIR—They know who you are visiting and when.

Ms Scott—That is right.

Senator MOORE—That is the advantage of the internet. If you are different in a community like that, you can find people with whom you meet on the internet, but if it is handled badly it can lead to all kinds of awful things.

Ms Scott—Yes. The internet is not bad per se; it is how it is used.

CHAIR—I want to go to the issue of dealing with suicide in schools. We have had an ongoing debate about whether or not you name it in schools. Youth Focus were here this morning. I have heard them speak previously about being much more forthright in naming it in schools, yet we have had other advice that you are better off not naming it in schools but providing really good support and education services about life, connectedness and how kids can strengthen themselves and connect to services. How do you view whether it should be named in school or whether you are better off not naming it but providing support in schools that deals with strengthening people and providing them with support programs?

Ms Scott—I am going to fall back on my caveat: I am not an expert on suicide. I have been noticing the debate on that in the media in terms of whether you should talk about a young person's suicide in the media. I noticed Patrick McGorry wrote a piece not that long ago saying that rather than not talking about it maybe we should. I think it is an evolving thing. Perhaps it is changing. I was interested in what he had to say, because he is far more expert than I.

CHAIR—We have heard from a number of witnesses issues of having a big fuss in schools where there has been a young person's suicide and then there has been a memorial: that may be having a negative effect because their peers see that person being celebrated and a big fuss being made of them. I think it is fair to say that we have had fairly consistent advice about how that may not be a good thing—at least that element of talking about suicide.

Ms Scott—Yes, and I imagine that in particular Aboriginal communities on this issue of multiple suicides it would be interesting to hear what other service providers but also Aboriginal people think about that as well. I suppose my efforts have been really concentrated on what are the positive interventions that we can do to ensure that children and young people are healthy and well. I am very pleased to go back to Fitzroy in December and see how it has changed since May 2008, a community rebuilding itself more positive things for kids and young people and

their families. The alcohol restrictions have made a significant impact but they need more help up there. But even so it is really good to see a community functioning well and coming together as a community through the Fitzroy Futures, where the organisations come together but there is community representation in their planning for their future. So it was tremendous to see that contrasted to May 2008, where they have experienced considerable family violence and a high number of suicides and having reported to me though this challenges that kids generally are doing a lot better in that community.

CHAIR—Thank you very much. It is much appreciated.

[2.21 pm]

HOPE, Mr Alastair Neil, State Coroner, Coroner's Court of Western Australia

CHAIR—Welcome. Thank you very much for making the time to come along today.

Mr Hope—Thank you for inviting me.

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

Mr Hope—As the State Coroner of Western Australia, I am responsible for the investigation of all sudden deaths. In that capacity our court investigates about 300 deaths by suicide each year. I was appointed the State Coroner in 1996, so for the 14 years that I have been responsible for the investigation of suicide deaths there have been between about 200 and a bit over 300 suicides every year. Over the past 13 years I would have read about 2,000 files relating to suicide deaths, I have seen the photographs of over a thousand bodies and I have read the suicide notes, where there were notes, of all of those people. So in my capacity as State Coroner I am painfully aware of the immense personal, social and financial cost of suicide in Australia.

In talking about those numbers, it does surprise me sometimes how consistent the numbers seem to be, which is interesting when every individual case seems so completely different yet at the end of the day we seem to have very much the same sort of numbers. That suggests to me that underlying problems that are constant are the drivers for the total number of suicides even though with individual cases intervention programs may be able to save particular persons at risk. In my capacity I expect to see a new mortuary admission form, which is the form that goes with a body to the mortuary, every working day. Today we have six bodies in the mortuary. Four of them are clear suicides deaths and one is a possible suicide death with a medication overdose. That has happened since I came here yesterday. Of the categories of sudden death we investigate, suicide constitutes the largest number. I am sure you are aware that suicide deaths, for example, exceed motor vehicle and motor traffic deaths in Western Australia, as they do elsewhere. Our figures in respect of motor vehicle deaths are that we usually have about 220, which again interestingly seem to be remarkably consistent although the cases are so different.

I have brought along a breakdown of our recent suicide deaths. According to our statistics, in 2008 there were about 310 suicide deaths and in 2009 there were about 290 relatively confidently determined suicide deaths with a possible another 11. So generally there seem to be slightly over 300 per annum at the moment.

The role of the Coroner's Court is to ensure that all reportable deaths, which includes deaths by suicide, are investigated. At the conclusion of every investigation there is a coronial determination, a determination made by a coroner, and findings are made as to the circumstances of the death. In most cases that is done on the papers and in a relatively small number of cases there is a public inquest. We only hold public inquests either in death in custody cases or where

we believe there is some type of public benefit or death prevention purpose to be served by holding a public inquest.

A review over recent years reveals a general gradual increase in suicide rates. When I started in the job there were about 240 I think and now there seem to be fairly regularly over 300, as I was indicating to you earlier. WA Police investigate all the sudden deaths, including suicide deaths, on behalf of the Coroner's Court. The evidence captured by the police is important in order to determine whether a death is a suicide and, if so, the circumstances surrounding the death. As I said before, death in custody suicide cases are inquested, but in other cases we only hold an inquest to highlight particular concerns.

I understand that you are particularly interested in the accuracy of statistics. I am not really a great fan of statistics. As a general rule I tend to find that they can be a bit rubbery. In Western Australia we have tried to be as consistent as possible. I suggest that our statistics are amongst the most reliable of the states and overseas with respect to suicide deaths. That is partly because we have a very centralised system and there are only two full-time coroners—the deputy state coroner and me.

In the country regions local magistrates act as coroners by virtue of their office and they finalise a significant number of cases, although even if the case is determined on the papers, we tend to do more and more of those. It is actually my view that the time has really come to move away from country magistrates dealing with coronial matters. I am not wishing to be critical of them when I say that, but I think the time has come for a more professional approach to coronial investigations. I particularly note with some of the files that I have been reading recently that in the country regions the quality of the investigations varies widely from one region to another. It depends very much on whether the local sergeant is interested or not. Quite often police are not all that interested in cases that are not criminal.

When compared to some of the other states, I believe our statistics are reasonably accurate. In South Australia I understand that the coroners do not make findings as to suicide. So in the NCIS where there are references to a determination of suicide that is often based on either what the police thought or what some clerk who has inputted the data believes. In Queensland they have a lot of problems because Queensland is more diverse than WA and there are a lot of country coroners. I note that Michael Barnes, the State Coroner for Queensland, has difficulty trying to get a consistent approach amongst the coroners.

When cases are not inquested there is generally less family pressure to make a finding that the death did not occur by way of suicide. If we have a public inquest, quite often there is pressure from families to find that the death is by accident or some other mechanism apart from suicide. That may be for a range of reasons. Sometimes we would have a suspicion that various family members believe that a finding of suicide might reflect adversely on their own interaction with the deceased person.

In respect of the accuracy of determination of suicide, there are obviously some cases that are very difficult to categorise anyway, particularly when there is no suicide note. Medication overdose cases are probably the most difficult, and I see quite a lot of those. Quite often the deaths are of people who are not normally compliant with their medications anyway. With those people it is very hard to know, because there may be a history of depression anyway. There is a

history of noncompliance with medication and there is no suicide note, so there is a real question mark as to whether the person just took too many tablets accidentally or whether it was a deliberate suicide. Single vehicle collisions are other instances of cases that are difficult to determine.

In addition to the uncertainty based on the objective circumstances, there are grey areas in respect of intent as well. There is often a question, particularly with young children, as to whether the person really appreciated the finality of the act. For example, I saw the death of a seven-year-old child who had hanged himself, and there is a real question mark in that type of case as to whether the child appreciated that it was for ever. There are also cases where there is a grey area between recklessness and intent. I particularly remember the case of a young Aboriginal girl who had been repeatedly sexually abused. She was driving a motor vehicle in a manner which was so reckless that it would be very difficult to decide whether she wanted to die or just did not care. So sometimes intent is not clear cut either.

Dealing with our own response to cases and what happens as far as we are concerned, as I said before we attempt to identify cases where we believe we might be able to do something to prevent similar deaths in future and we attempt to hold inquests in some of those cases. One of those cases was the 2008 inquest into 22 deaths of Aboriginal people in the Kimberley. I do not know if you have a copy. I have a copy here if you want a hard copy.

CHAIR—I have a personal copy.

Mr Hope—I can certainly provide you with a copy of that inquest finding together with the statistics that I referred to earlier. In that case it appeared that a number of the deaths were caused, or contributed to, by alcohol use. The inquest was held in a context where it was noted that the suicide rates for Aboriginal people in the Kimberley had increased dramatically in 2006. In that year there was an increase in suicide rates of Aboriginal people in the Kimberley of over 100 per cent. It went up from less than 10 to over 21, which contrasted with three deaths by self-harm of non-Aboriginal people in the Kimberley—and there are more non-Aboriginal people than Aboriginal people. In that case we made some real efforts to identify the causes for the suicide beyond the immediate triggers such as relationship breakdown and so on. It was obvious that there was a very high level of distress and despair experienced by the Aboriginal people in the East Kimberley.

A striking feature of the examination of the files was the high alcohol content of a number of the deceased persons. When I pulled out the 21 deaths for 2006, in 16 of the cases the blood alcohol level taken from samples from the deceased was in excess of 0.15 per cent. So in 16 out of 21 the blood alcohol was over 0.15 per cent, and in 11 cases it was over 0.2 per cent. That is a massive alcohol level, and a lot of these people were quite young. Those cases highlighted the association between alcohol and suicide, which I suppose plays a part in releasing inhibitions and so on. In addition, the general effects of alcohol abuse and the impact on families and so on would have been a major contributor in those deaths.

The inquest also identified serious problems in respect of child protection, education, employment, housing and cannabis use. Cannabis use was a matter that was concerning me initially but was somewhat overwhelmed by the amount of evidence about alcohol. But cannabis use and its impact on mental illness, and then on suicide, is something that is becoming

increasingly concerning to me. We have held a series of inquests also in respect of a number of other issues such as mental health issues and concerns as to whether mental health problems are being adequately addressed.

In respect of deaths in custody, we have to hold inquests. I have held a number of inquests where we have looked at, for example, hanging points. Obviously, while a person might be suicidal, very often the acts are impulsive. If there are obvious hanging points, that is a factor. Even after the Royal Commission into Aboriginal Deaths in Custody it seemed that cells were being constructed with hanging points. We held a number of inquests where we listed some of the recent deaths by hanging, with obvious hanging points. Unfortunately, from our perspective, the media have very little interest in deaths in custody. They are not particularly concerned about deaths of prisoners. Much of our ability to effect change is driven through the media, because effectively we do not have any power to direct anyone to do anything. The media embarrass people into complying with our recommendations, and they are not doing a great deal of embarrassing in respect of deaths in custody.

Turning to our court itself, we have experienced massive difficulties, since I was appointed in 1996, in obtaining adequate resourcing. I should say that the present Attorney-General, Christian Porter, is the first Attorney who seems to be interested in the Coroner's Court. He seems to be very supportive and on our side.

In respect of the bureaucracy in courts, we have received absolutely no support at any time. We have, for example, two counsellors who provide a 365-days-a-year service. When one of them was ill, we only had one grief counsellor providing a service for the entirety of Western Australia. I made a number of submissions to have some sort of increase in resources in that respect and it could not have had less impact.

In respect of IT, one of the concerns that I had was that we wanted to identify clusters of suicide deaths to identify regions where there were more suicides than one would expect. When I raised those matters within courts, it could not have possibly had less support. The priority would be absolutely zero, I would suggest. In a way, that is to an extent understandable because, within the courts context, they are concerned with listings and numbers of matters going to court and finalisations; matters such as whether or not resources are being allocated to identifying suicides are really outside their normal performance indicators or whatever the current bureaucratic concerns are.

The Law Reform Commission of Western Australia is currently conducting a review of the Coroner's Court, so any recommendations that you might care to make in respect of our resourcing and in respect of these matters would be timely.

Obviously we have access to a wealth of information. That information is provided to a number of organisations. It is provided to the NCIS and the Ministerial Council for Suicide Prevention. Deborah Robertson comes to our office regularly and reviews the files. The Telethon Institute for Child Health Research receives information. Other legitimate researchers involved in suicide research also are provided with access to information. You have heard already, I think, about our interaction with ARBOR and other such organisations in respect of support for people.

In respect of the causes of suicide and so on, I do not think there is a silver bullet which will provide an answer to all cases or reduce suicide rates. Obviously low self-esteem, sexual abuse, hopelessness and depression are factors. I can make a few general observations from my own perspective, thinking about these deaths over a number of years. I am a great believer in positive health measures. I am a great believer in positive action. In the case that we did into the large number of deaths in the Kimberley, Professor Fiona Stanley spoke of how important she found it for young Aboriginal people to be playing sport, playing football. The involvement in activity like that improved self-esteem in young people, which made a significant difference.

I believe it is important to have a diversity of interests so that people's whole life is not focused on, for example, a relationship. If you are going to split up with your girlfriend, it is perhaps not quite so bad as it could be if you are playing in the grand final of the football that weekend. I am a great believer in social interaction, not just computer interaction. I believe in stress relief and escape from mobiles and BlackBerrys.

I believe that increased pride is something that we need to foster in our community. I can remember people speaking years ago of being proud but poor. I do not think that exists nowadays. I think people who do the right thing should be proud of what they do. There is growing materialism in our community. That is very harmful, particularly the belief that people who have not got material possessions are somehow a failure in life. I can tell you that I have never seen a case of suicide where a person has killed himself or herself because there was not a second bathroom or three toilets in the house. But I have seen a lot of cases where young people have killed themselves because they thought their parents did not care because their parents were never there.

The sexual abuse of children is a huge factor. It is difficult to pick up just how extensive it is because it is not something that necessarily comes out in the investigations. Sometimes a suicide note will reveal that there has been sexual abuse. Sometimes someone will say that the deceased person spoke abut sexual abuse. As far as I can see, we are just getting the tip of the iceberg as far as that is concerned.

Family dysfunction is obviously a big factor with the increasing split-ups of families. Again that is perhaps something that does not come across quite so clearly in the files as it does in our office. I certainly get feedback from staff in a lot of cases that 'this family is a very dysfunctional family when we interact with them' even though it may not appear so from the evidence.

Mental health is of course a major issue. The feedback that we regularly have is that families would like to be more empowered to know more about what is happening with their loved one. Take, for example, if there has been a past act of attempted suicide. We have had cases where the family did not even know that that had happened and felt that they had not been placed in a position where they could adequately monitor their own loved one. Families are sometimes seen as a problem. The reality is that often they are the carers who have to look after the person when that person leaves the psychiatrist or psychologist. Confidentiality is an issue that needs to be addressed but should not be an excuse for not keeping families in some way empowered to know what to look for, even when families are part of the problem—and that is something that needs to be addressed as well by the mental health professionals.

Substance abuse is an obvious contributing factor and we see more involvement in particular by cannabis and of course by amphetamines, cocaine and all the drugs that are a problem. Cannabis, with its tendency to lead to schizophreniform disorder, schizophrenia and so on is having an unwelcome and increased impact. A number of Aboriginal people have spoken to me about that as well.

I make the observation that, while a number of the deaths seem to be totally unexplained by the evidence, some of those deaths may be sexual abuse cases and some of them may be cases where there are parental expectations and where family pressures have been placed on people. I can think of a couple of cases of doctors who have taken their own lives. They were doing extra training and they were not doing as well as they expected and they just could not accept that their family's expectations would not be met.

In respect of a couple of matters I noticed you were discussing with the last witness, I refer to suicide and information about suicide, particularly information in the media about suicide. There is definitely a copycat problem but I believe that the fact of suicide and the problems associated with suicide can be spoken about openly and should be spoken about openly.

The copycat problem tends to occur more when people have a direct knowledge. You quite often see families where one family member suicides and another family member suicides. Also, in Aboriginal communities where people have come across a person actually hanging. They know the person, it is right in the forefront of their minds that suicide is an option and they take it themselves. But I think, generally, non-inflammatory, non-ghoulish coverage information about suicide should be out there. I was interested to hear the last speaker also speak about Fitzroy Crossing, because that is one of the places we are particularly concerned about. It seems that the suicide rates are down there as well. More children are going to school. There is a huge reduction in the number of people turning up at the emergency department at the hospital and reported offences to the police are way down. So that is an example of a success story. That is all I have to say initially.

Senator ADAMS—Thank you. It was very interesting. Of your numbers, what percentage of your cases would have a mental health history? How many would be just out of the blue, completely and utterly for no reason whatsoever, no note left? Is there a percentage—for example, 75 per cent would have a background of mental health problems?

Mr Hope—It possibly depends a little on what you mean by 'background of mental health problems'.

Senator ADAMS—Just the fact that that person had actually presented to either a GP or somebody. I come from a small rural community and just knowing what a suicide in the community does—it devastates the whole place. If the family know that that person had problems and they probably went to Bunbury or to Albany but did not go to the mental health team when they visited because everybody would know and then, out of the blue, completely and utterly—it is devastating.

Mr Hope—There are probably relatively few that are totally out of the blue but there are a considerable number of people who have had some form of treatment for depression or who have seen their GP or whatever. There is a whole range within that category and there are a

number of people who obviously have had problems who have not sought professional treatment. But I would suggest the number is fairly small where there is something completely unexpected and there is no forewarning whatsoever. In most cases, people with histories of problems and distress, anxiety and so on may not have been treated. I could possibly give you the statistics on the numbers who have actually had professional help.

Senator ADAMS—Can we get an idea of the number of people who had sought help and the others—

Mr Hope—A significant proportion would have had some sort of mental health treatment. I could not give you an exact figure off the top of my head, though. If you are counting the people who have also seen their GP, who have had some level of anxiety or depression, it would be a significant proportion—probably half or so. For example, take the Aboriginal death cases, a lot of those people would not have gone to see a doctor about it, but it would not take too much exploring of the background circumstances to see that the person was obviously depressed and perhaps suffering from clinical depression.

Senator ADAMS—Something else that had happened.

Senator MOORE—What percentage leave notes?

Mr Hope—Not many.

Senator MOORE—I would not have thought so. The number would be quite small.

Senator ADAMS—As far as the families are concerned, when there is a suicide do you have someone who talks to the family and, more or less, investigates the evidence, finds out what the person was like before? Or do the police do that? How does that work?

Mr Hope—The police investigate the circumstances of the death, so they should be speaking to the family members and finding out the background. We provide the family with a grief pack and our grief counsellors write a letter inviting them to contact them. So quite often we do get feedback from the family through the grief counsellors and then through the family generally contacting our office.

The investigative role is with the police. They are expected to find out the circumstances surrounding the death and obviously, if there is a motive for a person to take their own life or there are mental health issues, that is something the police should be identifying. We specifically ask them to find out about the mental health. That is something we actually ask the police to find out about.

Senator ADAMS—I guess the other thing in the country is where there is a single-vehicle accident and a loan tree on a very straight stretch of road. Those are the issues to which, once again, in country communities there is stigma attached—did they or didn't they? Were they getting through a fence with a loaded gun? With all those sorts of things for me it is hard when you come from a small community where everyone knows everyone and it is almost cruel the way the families have to suffer. And then there is not really much support for them because to have a psychologist or a psychiatrist available anywhere once again there is a six- or 12-months

wait and that might end up with somebody else having real problems themselves. It is just so hard.

Mr Hope—I could not agree with you more. In fact, one of the things which has disappointed me most about our inability—and this is one of the reasons I mentioned the resourcing issue—is that we have not been able to provide any face-to-face counselling in the country because of the fact that we have had only two grief counsellors. We actually have temporary funding for three at the moment—I am hoping it will be made recurrent. With three counsellors, the very first task I have asked our senior counsellor to do is to go out into country regions to find out what the resources are so that even if our counsellor does not go out we are aware of, for example, victim support service people or a nurse at the local hospital, someone who can be called on to provide some face-to-face interaction at that early stage, even if the subsequent ongoing counselling is passed on to somebody else.

Senator ADAMS—I think it is terribly important. With community members, you can see someone walking up one side of the street and people physically dodging over to the other side of the street so that they do not have to confront that person because they are embarrassed and do not know how to do it. It is really hard. In the city, I guess you can get away with it a bit more because people do not know one another in quite the same way. It is very sad.

Mr Hope—In some of the country areas, the description has been given to me that whole communities are almost paralysed with grief, especially when there has been more than one suicide. If there have been two or three suicides—

Senator ADAMS—Narrogin has been an area where Indigenous people took their lives but as far as the whole community was concerned, they were all in grief—not just the Indigenous people but everyone was saying, 'What's gone wrong; why did it happen?' There are all the issues that go with it. It is a community which appeared stable, apart from the families feuding and things like that, but that has been going on for generations so it is not new. That community is struggling to get back on its feet.

Mr Hope—We are going to have an inquest about those suicides. I do not know whether it is going to achieve some of the things that we achieved, hopefully, with the Kimberley one. Sometimes a benefit of the inquest is to show that there are positives as well as negatives and hopefully that may happen with that community. A really classic example was just out of Fitzroy Crossing in Mindi Rardi, a small Aboriginal community. In just about every second house there someone had either suicided or died some sort of tragic death. You can imagine what the community at Mindi Rardi was like—they were absolutely unable to go forward.

CHAIR—When we were in the Northern Territory we had evidence there that in Aboriginal communities on average a person will have had 12 traumas in their life and trauma was counted as a death of someone close to them, in their family or their community. If everybody in the community is suffering that sort of trauma, moving forward is really difficult.

Mr Hope—It is a very full-on interaction that they have, too, compared with what happens in the city, where everything is a bit sanitised. In an Aboriginal community, for example if young children have found the deceased hanging, and then the body is still there for a while and everyone is standing around looking at the body for a period, everybody in that whole

community has seen the body and has seen the police come up, it is all very much in front of them.

CHAIR—I would like to go to the issue of resources, following up the comment that you made. This also brings to mind Narrogin. Over the last couple of days we have been talking a bit about Narrogin and the fact that Oxfam is still providing funding for a part-time psychologist to be able to come out to the community. But they still do not have a full-time male or female social worker, and their Indigenous support worker has just pulled the pin because he has been working flat out. That is what it is like living in community when you are the sole support person. He has just pulled the pin because he is having trouble coping as well. So here we have a community where we know very well that there are problems, but we still do not seem to be able to get resources for that community—let alone any of the other communities where there is potentially less need on the surface, and people may know about it but it is not so obvious.

Mr Hope—It is pretty hard to get people out into the country, for a start—not just social workers and psychiatrists. We deal with hospital deaths and so on. In some of the country regions they are bringing in overseas doctors who are working in the emergency department when they have not done anything in emergency for 30 years. All sorts of problems are happening. Basically, I have told my secretary that if I am sick and we are in the country to get me on a plane and fly me to Perth and pretend I am all right! I think it is a common problem in the country. Obviously, when mental health resources are strained anyway, in some of the country regions—I would expect throughout the whole wheat belt, for example—they are virtually non-existent.

CHAIR—You made comments around resources for counsellors but also about clusters. Could you go into that in a bit more detail?

Mr Hope—Our concern was that we did not have any proper computerised file management system in our office at all, or any computerised system that would help us to identify anything about what was happening with our matters; whereas, every other section of courts in WA has had some sort of IT software system put in to help them manage their caseloads and so on. Every time we were about to get something we would be bumped off the list. One of the types of things I wanted to monitor were clusters of suicides and things like that. So at the moment we are very much reactive. We get feedback from local people who tell us there have been a lot of deaths in a particular area. I would like to be a bit more proactive and be able to act more quickly and to actually monitor things. When I raise those sorts of issues it is just treated as highly unimportant by the bureaucracy—for example, that was part of a business case and they thought it was so unimportant they did not even present it to the minister.

CHAIR—So you still do not have resources for doing that?

Mr Hope—Hopefully we will have some resources. I have not actually seen this happen yet, but we are getting an add-on to the NCIS system which I hope will enable us to target these particular problem areas. I believe that is underway.

CHAIR—A number of other states have raised issues around being able to properly identify the number of Aboriginal people who have committed suicide because the identification process,

in terms of the forms, does not always identify someone as Aboriginal. Is that the case in WA or are you fairly confident you have the figures pretty well okay?

Mr Hope—Aboriginality is a question our police ask about. How accurate is it? It is a pretty tricky area, but it is certainly something that we ask about. And it is being asked because we get some answer about whether or not someone is Aboriginal.

CHAIR—Okay. Thanks. We met with the ARBOR mob yesterday. They were talking about how your grief counsellors contact them in the even of a suicide and the notification could take anything up to two weeks because of various delays. Our Australian system is a legal system rather than a medical system. ARBOR model a lot of the work that they do on the American system. Because of the workload that your office has, they say that sometimes there is up to a two-week delay. Have you discussed that with them? Is there an issue there? I suppose I have a concern that, if they are then contacting the family and relatives of the person who has suicided, two weeks can be a long delay between when the suicide occurs and when the family is offered some support from their organisation. I am wondering if there is an issue there. If there is, is there a way that that time delay can be reduced?

Mr Hope—Our approach is to leave it to the families whether they want ARBOR to be involved. So we raise the issue with them. Then they come back to us. If they say that they want ARBOR to be involved, we notify ARBOR and say, 'The family wants you to be involved and these are their contacts and this is the person you should contact.' If the family says that they do not want ARBOR to be involved, we advise ARBOR that they have said that. But I do not know exactly what the delay is. But it is our view that we do not push things on families, because we are intrusive enough as it is. We leave it to the family to make that choice.

CHAIR—Okay. It was not clear from them yesterday that you go through a process of notifying the family about ARBOR before you tell them.

Mr Hope—Yes. We act as a sort of intermediary. Sometimes, people do not want to make a decision about anything straightaway. It might take them a while to decide whether they want to speak to anybody or not. We encourage them to use ARBOR, but it is not compulsory.

CHAIR—Okay. Thank you.

Senator MOORE—You talked about your resources issues. When the coroners from around the country get together, and I know that that happens at different times, is that an issue that is shared by all of you or are there some states better off? Or is it the ongoing resourcing and the interaction between the governments and you? Is that something that is a national issue?

Mr Hope—It varies from state to state. I am fairly optimistic about our current Attorney-General, as I said. The Law Reform Commission is doing a review as well. If they recommend that we take on more responsibility, I am reasonably confident that with the current Attorney-General that would be something that would be pushed and encouraged, which is good. For a long time, we have been the forgotten people, because in 15 years we have never had an increase in FTEs at all. We are the only part courts who have had no increase whatsoever. I have only one counsellor assisting who is a recurrent staff member. We had temporary funding for one other person. Now we have temporary funding for two. We are really at the bottom of the heap. State

by state it is completely different. All the systems run differently and are different. In Queensland, thanks to Dr Patel, who has been very helpful for them, they have considerably more resources. They have a lot more coroners, a lot more counsel assisting and a lot more resources than we have. Victoria recently had a review. It seems that something bad has to happen. Our mistake has been not letting something really bad happen. In Victoria, there was a problem about wrong bodies being buried and then bodies having to be exhumed and things like that.

Senator MOORE—That would cause a bit of a stir.

Mr Hope—That was a bit of a stir. Then there was a big review, another Law Reform Commission review, and subsequent to that some more resources have been pushed into Victoria. So they have been picked up a bit. South Australia, I think, is reasonably content at the moment. They have a State Coroner and a Deputy State Coroner full time, and they have got a couple of counsels assisting. For their amount of workload I think that is reasonable. New South Wales, I think, is pretty much a basket case—they are really badly resourced.

Senator MOORE—They are a basket case, full stop.

CHAIR—I wasn't going there.

Senator MOORE—I am happy to say it. It does not worry me. The other thing concerns the different ways that statistics are kept. I know you share. The way you presented your view on statistics is very much the way I feel about them, but nonetheless it does seem to me odd that there is not some form of national consistency in the way that statistics are retained in these areas. At the meetings that you have do people share best practice and suggest differences—allowing for individual state pride of course?

Mr Hope—It is something that has been on the agenda from time to time. Unfortunately, progress has been relatively limited. But it is something that we all agree would be a good thing, but we have not really achieved much. It is partly to do with the actual complexities of our own evidence gathering procedures and the different sorts of structures that we have. Even the funding to each of the Coroners Courts is quite different. Some of the counsels assisting come from the DPP and some of them are police and we have got a couple of people in our office. It is all a bit of a mishmash in respect of the structures of the offices and so on. But there is a general consensus that it is a good idea.

I think that the move is towards more findings of intent, because that was something that the Suicide Council raised with us. In a number of jurisdictions there were no findings about intent and it was not possible to determine whether or not a death was a suicide anyway even if you got hold of the file and read through it. I think that has probably been picked up on and improved. I mentioned it to Michael Barnes in Queensland. He has been trying to get much more consistency in his state. So generally we are trying to work towards it. I do not know whether South Australia is improving in that regard.

Senator MOORE—We heard evidence in Queensland, and I knew about the issue in Queensland with the different regional centres having a different focus. But Barnes has been really pulling it together and it has been the focus of the last Attorney-General. I am not quite

sure about this one but the last one had this as one of his key aims. He was a regional solicitor so I think he brought that to his process.

But what we did hear about in Queensland was the focus that came out through a range of interests about clarification of stats around children. When findings came to a coroner about child suicide Queensland has actually introduced a methodology whereby they keep stats for kids—and I have forgotten the age. Up until then everyone under a certain age was kind of lumped in together as a possible suicide, but now they have got clearer statistics—

Senator ADAMS—Ten to 14.

Senator MOORE—Ten to 14 was the focus, because they had actually had some cases. It is always stimulated by an event. The way they presented the evidence is peculiar to Queensland at this time and I was wondering whether that particular focus had been considered at your national meetings.

Mr Hope—No, that particular age group has not been the focus. It could be, but I do not really think that we have a huge number of deaths in that category in WA because we are so centralised. The Deputy State Coroner and I have basically decided, so there is consistency because there are only the two of us.

Senator MOORE—It is a good position. One of the things the committee has struggled with over many years has been the issue of privacy, and you mentioned it in your opening statement. We have had evidence from the whole range of views about confidentiality and privacy and the right of families and carers to have more information. In your role where you would be caught up in it a bit, I would imagine, in this terms of seeing the people's views at the end, have you sensed any movement within that debate? It almost seems as though people know the debate but it is too hard.

Mr Hope—It is certainly a big issue. Our experience recently has been that there seems to be a move towards a consensus that you can address confidentiality issues. Especially in an acute suicidality context, families do not necessarily need to know the nitty-gritty of an issue, but they can certainly be alerted to some of the things to look for and some of the concerns. That is not a breach of confidentiality. If someone is at risk of harm and the matter comes up during a discussion between the practitioner and the patient—the possible suicidal person—there really should be an onus on the practitioner to resolve that with the patient and say, 'I'm worried about this issue; I need to tell your parents that this is a problem,' and then have the patient accept that that would be reasonable.

Senator MOORE—If you can get consent you are fine.

Mr Hope—You cannot pretend it did not happen and keep the parents in the dark without doing anything. I think there is a bit of an onus to raise an issue if it is something that is directly a confidential point and it is a life-threatening issue.

Generally, in respect of empowering people, I think there is an onus on practitioners to give carers some information—enough to empower them to know things to look for. An example is the sort of thing to look for to see when the patient is not complying with their medication—the

way that the person is likely to behave if they are not taking their medication—so that the parents can pick it up.

CHAIR—I want to go back to what you record. We had the Ethnic Communities Council here earlier and we have looked at the new strategy, which highlights the number of suicides in the CALD community. The ECC were saying that it is quite difficult to get stats because ethnicity is not necessarily recorded. Is that an issue that has been brought up with you? When we have asked other people during the day about this it was clear that they did not have a good handle on this, and the stats that are quoted in the strategy are actually overseas stats. Has anyone discussed with you how they can get a better handle on ethnicity and issues around the CALD community? There seem to be some very significant issues there. Quite often you only start getting a focus of resources when you can start proving that it is a big issue.

Mr Hope—It is certainly something that has been discussed amongst the coroners, particularly when issues were raised about Indian related deaths in the context of assaults on Indian people in Victoria and that sort of thing. A question was asked about how many Indian people may have taken their own lives or may have been the subject of homicides and things like that. The fact is that we do not keep those statistics. It is something that we could ask police to ask. One of the big questions for us is what we need to ask police to ask. That is not something you can just change every five minutes because you have to give them a form and it has to be sent to every police station around WA—and everyone is going to lose it!

I have not seen a lot of evidence to suggest that ethnicity is a huge factor, to be perfectly honest. I see the problem as running through all cultures and races—all people. We take aboriginality but otherwise we have not particularly focused on a group, and I cannot remember people writing to me and saying that people in a particular category are suiciding more often or that there is a big problem there. I have not really seen the evidence to justify calling on the police to gather that information. It would be a bit fiddly, because I do not know how you decide whether a person is of, say, Indian extraction. How far back do you go? Who are you categorising as being an Indian person? I know there have been a number of assaults on people who have a particular appearance but they may have actually been living in Australia for two generations or something like that.

CHAIR—Yes. The points that were being raised with us are the issues around people who have been in detention—people coming as refugees. They are fitting into a new life. If they are young people and they are going into schools, they are often being put into grades where they do not have the necessary numeracy and literacy skills to cope. They have had trauma where they have come from, so they have to deal with those issues. Their parents do not necessarily pick it up because they are dealing with their own trauma. That was the background to the discussion we were having. If I understand what you are saying correctly, you have not noticed a significant proportion of people from the CALD community completing suicide.

Mr Hope—No, I certainly have not. I am thinking of all the files I have read but I cannot even think of a lot of cases where that has happened.

CHAIR—The other issue that the Indigenous team from the Drug Research Institute raised with us is the lack of research on alcohol and drug related issues with regard to completed suicides and what role drugs, in particular, have played in suicides. A high degree of substance

could be in someone's system but there is still a lack of research in what role that has played in suicide. You mentioned, particularly in the Kimberley suicides, that there were high levels of alcohol present.

Mr Hope—Very high, yes.

CHAIR—Are you aware of any research or been asked to be involved in any research into that issue?

Mr Hope—I cannot recall a lot of research. It seems fairly self-evident to me that the statistics reveal that there is a strong correlation between alcohol and suicidality and the problems associated with alcohol and suicide as well. Foetal alcohol syndrome and so on is manifestly bad. I do not really know whether there is any point in researching it. It is obviously a bad thing. We have picked up on cannabis, because we have had a number of deaths of people with mental health problems, and quite often there has been clear evidence of cannabis being a precipitator for mental health problems and drug induced psychosis and so on. There has been some pretty clear evidence in those sorts of cases. I think the evidence is pretty clear.

Senator ADAMS—I have a general question as far as your role as a coroner is concerned. With regard to sudden death—not necessarily suicide—I have heard lots of complaints about the time it takes from when the person passed away to the time when an interim death certificate is issued and then when a final death certificate is issued. How are you going in that respect?

Mr Hope—Those are exactly the sorts of issues I am talking about.

Senator ADAMS—I know; that was why I wondered.

Mr Hope—I mentioned that the present government did agree to give us some extra money, although it is all contingent on the Law Reform Commission's determinations. We were given that money in August last year. By the time we had actually employed anybody and gone through all the HR things, it was pretty much December. We have now got a person, a clerk, who is working full-time to help our clerks to finalise our files so they can get through to us. And just yesterday we started a person who is working part-time as a coroner, using this funding that we have got, and he is just resolving files for us. So we are attempting to address that backlog as much as we can.

There is a big problem with the police as well. Our coronial police have got about 300 files that they have not been able to finalise, and they are really struggling. They just gave 70 to the major crime squad, who are probably not doing a huge amount. So we have our backlog, and they have another big backlog that is sort of sitting there. We have just recently got some money, so actually we have a few people beavering away non-stop to get these files processed. But that was the first time we had had any injection of funds in 14 years.

Senator ADAMS—That is good to get on the record anyway.

Mr Hope—Yes. Assuming that we get a continuation of the funding into next year, because the Law Reform Commission's report will not come out until late next year, and depending on how much additional funding they give us, if there is enough to keep that person going then I

would like to see that person who is helping finalise our files—that is the only thing he is doing at the moment—just continue on, because we are not going to get the backlog into a reasonable condition by 30 June. Sometime next year we would catch up reasonably with the backlog if we have continued funding.

Senator ADAMS—So are you reporting to the Attorney General? Do you report back there via an annual report?

Mr Hope—Yes. We have an annual report, and I have been keeping the Attorney reasonably appraised. As I said, the Attorney at the moment is quite supportive. But, as I said before, we have not really had much support from our department; they have never been supportive of any of our requests for funding for our budget or whatever.

Senator ADAMS—Nice! I mean, death is hard in any area but even harder, I think, with something like this, when you are waiting and waiting and waiting. And then of course probate cannot take place until 18 months later. I have personally gone through the whole system very recently and, doing what I am doing, it has been pretty jolly hard to get it finalised.

Mr Hope—It absolutely amazes me that we do not get more complaints. It amazes me that more people do not complain.

Senator ADAMS—Yes. I have had a few through the office but, probably because of my personal situation, I have been able to say, 'They are doing their best, but …' Just for the record, I was very, very happy with the support I got from your office.

Mr Hope—That is good. We have had a very small core of staff and just about everybody is owed massive amounts of leave because people have not been taking leave because they wanted to get things done. We have just had a terrific commitment from everybody in our office. If I ask someone to stay back and work they will do it, and they do not care about whether they get paid or not; that is just the sort of ethos of the office. People really care. When the Attorney's advice came through in August that they were going to give some additional funding to help us deal with these things, there was a massive cheer in our office. That is just how committed our staff are and how pleased they were that we could actually start to give people a better service, because it hurts us as well. We hate holding people up. It is hurtful to us, and our staff are very distressed by it. They want people to get information in a timely fashion. They really care.

CHAIR—Just as a general reflection, it is often that way with essential services, and NGOs are the same. They keep running. Government relies on them very heavily—they rely on people's goodwill and commitment to service. But, anyway, that is a personal reflection.

Mr Hope—That is right. If things go badly wrong, that seems to be when you get the funding. I guess because we have been working extra hours and we have been coming back and doing things we have reduced the number of complaints, so I do not know whether that was a good thing! And we have done things like making sure that matters are processed so that funerals can go ahead. Everybody just treats that as the number one priority, and if we have to do something we just do it.

Senator ADAMS—There is nothing worse than communication sometimes with the general public. They might go ahead and organise a funeral service and then, unfortunately, things are held up and they just do not really understand. Nobody expects these things to happen. But then they are at a loss as to how to deal with the situation and then think, 'Well, there's a spare slot there; we can do it on such and such a day and everyone will be here,' and then all of a sudden the body is not available to be sent to wherever it has to go.

Mr Hope—Essentially, we never hold up funerals by our own mistakes. Where funerals have been held up it is sometimes funeral directors not having understood that the process might take a bit longer. People objecting to autopsies can cause delays. Funeral directors who understand that warn people so they do not organise a funeral until those matters are resolved. Our office basically reacts with that as our No. 1 priority and trying to get people answers is our No. 2 priority. That is why some of the other things have taken longer and longer.

CHAIR—I have two questions that have come out of evidence we have had in other states. Do you hold inquests for suspected suicide sometimes? If you suspect a suicide, would you hold an inquest?

Mr Hope—Not just for that reason. We only hold inquests where we see that there is a positive purpose to it. If there was some belief that somebody was withholding information and the only way we could get it was by an inquest, we would have an inquest. It is usually much quicker and more effective in helping us resolve the matter if we just ask the police to find out what happened about this or that and chase up further investigations as a result of that questioning.

CHAIR—The Public Interest Advocacy Centre in New South Wales suggested that coroners make recommendations after inquests for suspected suicides. You can make recommendations anyway in WA, can't you? You do anyway.

Mr Hope—Yes, but usually after an inquest where we give everybody an opportunity to be heard as to the types of things we might make recommendations about.

CHAIR—But you do not need to be given any additional powers to do that because you already have those powers, don't you? It is up to you to decide in the public interest—

Mr Hope—That is right. We have the powers to make comments and recommendations.

CHAIR—Not all coroners apparently around the country have those powers. Is that right?

Mr Hope—I do not know whether they are thinking about in the cases that are not inquested. It may be in the cases that they do not inquest they do not make recommendations, but we would not normally make them anyway. If there was a death prevention issue that we wanted to get out there, we would hold an inquest, otherwise no-one is going to know about it.

CHAIR—Another issue that has been raised is the role of the police in assisting people who they think are at risk of suicide. Have you had any involvement in that area? Do you have any comments to make on that? We have to look at the effectiveness of agencies in terms of dealing with people at risk of attempting suicide.

Mr Hope—The WA Police are a huge amorphous mass, are not particularly disciplined and are completely different from area to area and individual to individual. A lot depends on the particular police officer and the particular location. One very good innovation by WA Police to their great credit is the multipurpose, multifunctioning units that have been constructive in the country. That places a child protection worker and a police officer in the same room. I think that is a very positive step. It helps to have them both know about the issues affecting each other.

CHAIR—That is happening in the bush though, but it is not necessarily happening in the city. We have been to the Balgo centre several times. I agree with you. I understand that one in Warburton is working well as well. So what you are saying is that it is a bit ad hoc around the state?

Mr Hope—Very much so, yes. We have had police called to a scene where somebody is apparently suicidal and sometimes they have acted positively, well and efficiently and other times they have not. Sometimes they have mucked around when they should have stepped in to save someone's life. It depends very much on the particular officers, the amount of training they have had and who they are.

CHAIR—Around Australia we have heard about the lack of consistency in training in addressing mental health issues for front-line services—ambulance officers, emergency service people, emergency departments and the police. There seems to be even within states and certainly between services an inconsistent approach to training.

Mr Hope—I think I made a recommendation about that in one of the inquests. Certainly it is a very important topic. Police definitely need to train their people more with respect to mental health issues. I have had some feedback that they are improving their training, but I do not know the extent to which that is true. It is very important for them, apart from the suicide issues, just for their protection. The two cases where police officers have been shot and were almost killed were where there were mental health problems. Police were inadequately skilled really to respond and put their own lives at risk.

Senator ADAMS—Do you in your role get an opportunity to speak to the classes before they graduate about what the role of the coroner is and how important it is what they do and don't do?

Mr Hope—I do not personally, because there is only one of me. Our office has tried to become more involved. I have gone along to graduation groups. We sometimes have had involvement and sent someone down to explain what the Coroner's Court does. We are eager to increase education. That is a big issue. Training at the police academy in respect of coronial matters is pretty much nonexistent. We are very eager to have that upgraded and have more input into that.

Senator ADAMS—Can you put that in your annual report this year?

Mr Hope—We very possibly could.

Senator ADAMS—I think it is terribly important because people are getting busier and busier. Out in the rural and remote areas the pressure is on. If police really understand what you

do, they could help families a lot more by being able to explain the process. Five minutes could really clarify everything and they would know what to expect.

CHAIR—That is an issue that has come up with particularly bereaved parents. They have not been told what has been going on at all. If the suicide happens at home, they are locked out of the home and have nowhere to go. It varies in different states, but sometimes they have not been told what is going on and have not been given any numbers to phone for support. Even if the police could give them a bit more support, it would be useful.

Mr Hope—It would be very helpful for us as well. We have two police officers attached to our office, although one of them might be going away. When they are there a lot of the time they interact with police, often in the country, who are investigating sudden deaths and do not know what to do. About 80 per cent of their work is trying to help them and tell them what they should be doing. It would be an awful lot easier if the academy taught them in the first place. Even so, I think it is great that they do interact with somebody who knows a bit about it so they are passing on reliable information.

Our brochure goes to every family. It is mandatory that the brochure be served before an autopsy, so every family will get a copy of our brochure. Our grief counsellors send a letter to all families of suspected suicides. At least people can contact our counselling service, which will tell them about factual issues as well.

CHAIR—Thank you very much for your time. We very much appreciate it.

Mr Hope—It has been my pleasure. It is extremely important to me, as you can imagine.

Committee adjourned at 3.35 pm