COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Suicide in Australia

TUESDAY, 4 MAY 2010

ADELAIDE

BY AUTHORITY OF THE SENATE

SENATE COMMUNITY AFFAIRS
REFERENCES COMMITTEE
Tuesday, 4 May 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, Moore, Siewert and Wortley

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 9.03 am

JOHNS, Mr Mark Frederick, South Australian State Coroner

CHAIR (Senator Siewert)—Today the committee is continuing its inquiry into suicide in Australia. I would like to welcome the South Australian State Coroner. I understand you have been given information on parliamentary privilege and the protection of witnesses and evidence. I would like to invite you to make an opening statement and then we will ask you some questions.

Mr Johns—Thank you. I suppose by way of an opening statement I would like to say that I have been the South Australian State Coroner for 4½ years. When I came to the role I was shocked by the number of suicides that take place in South Australia weekly, monthly, yearly. As a person that I thought was a reasonably well-informed member of the public, I simply had no conception at all of the prevalence of suicide in South Australia. I am not saying South Australia is any different from any other state, I cannot speak for the other states, but I thought I was a reasonably well-informed individual but suicide had, fortunately for me, I suppose, never touched my life and in fact it had not even entered my consciousness except as very distant anecdotes of events that had happened to people who were remote from me. Then I found right from the first day, as I was looking at coronial files to make findings, that this was not the rare event that I had always assumed it was from my participation in society and my reading of newspaper reports and my mixing with other people but in fact it was far more prevalent. I suppose that is the first thing. I came to this role from a middle-class background, not unduly privileged but of course I had the luck and the privilege of a middle-class background and the luck of having a good education and a university education. But I simply was not aware of the prevalence of suicide in our society.

Right from the beginning that made me think that if I was not aware of it then a number of other people would not be aware of it either. The view I have now reached, having spoken to lots of police officers and other individuals about the subject, I think it is a commonly held view that those people who are exposed to the reality are of the view that a large majority of the public simply have no idea of the reality. Suicide is not reported much in the newspapers and when it is the media is very nervous about the risk of copycatting, and as a result of that I think it tends to be underexposed in the popular press.

Just to return to my role and the coronial function, you have probably had evidence from my counterparts Alistair Hope and Michael Barnes, so you have a general idea of how the coronial system works. I will not laboriously go through that again other than to mention that in South Australia our system is broadly similar to that in the other states but there are differences between each of the jurisdictions. I will mention some of the characteristics of this jurisdiction in South Australia. There are only two full-time coroners. Although every magistrate is by dint of holding the office of magistrate a coroner, the practice in South Australia for at least 40 years, I would say, has been that only the full-time State Coroner and of more recent times, in the last five years, we have had a deputy state coroner, do coronial work.

The office in South Australia consists of 15 staff, and in addition to that we have the two full-time coroners. We have approximately 2,000 reportable deaths a year. Of those, 1,200 come via South Australia Police. They might be deaths that occur by accident or road accident, the sudden death in the home of an elderly person or, of course, suicides. The other 800 come from the medical system through public and other hospitals. Each of those 2,000 reportable deaths a year is investigated to a certain level. The preliminary investigation will be medical inquiry into cause of death, autopsy and so on. I am sure you have heard all of that from my counterparts, so I will not labour it. The early stages ensure that we are going to be in a position to establish cause of death and to establish the identity of the deceased. Those are the immediately pressing things when the death is first the reported. Then there are issues to do with release of the body to funeral directors, next of kin and so on. After that there is a process of review within our office. It is a case of culling cases which are deemed not to require further investigation on a continuing basis, until you filter out only the cases which require the highest level of investigation. Bearing in mind that we have limited resources, we have to cut the cloth to fit the workload.

Between the two of us we would hold 50 or so inquests a year. An inquest can last anything from half a day to three weeks or more. Inquests are not easy things to organise, because witnesses are not always readily available and waiting at the door to come in one by one. We try to accommodate people’s lives, so sometimes inquests get split, disrupted or adjourned. Organising an inquest is quite a heavy logistical task, and that limits the number that one is able to hold. In addition to inquest work, we divide the files between us. Every one of the 2,000 reportable deaths will be seen either by me or by my deputy, and a decision is made about whether there will be an inquest or what we call a ‘finding’ issued.

The Coroners Act 2003 creates two avenues for disposition of reportable death reports to us. One avenue is the inquest avenue; the other is the making of a finding. The act makes it plain that, if there is to be an inquest, the inquest will determine and make findings about the facts and circumstances surrounding the death, including of course the cause of death. The circumstances that surrounded it are also to be found, in the words of the act, ‘as much as practicable’. If there is not an inquest, the act says simply that there will be a finding as to cause of death and nothing more. When you make a comparison between those two sets of words, ‘cause and circumstance’ in the case of an inquest or actual ‘cause of death’ in the case of a finding, it becomes plain that our jurisdiction limits us to medical cause of death when we have a finding, and that excludes reaching conclusions about a person’s intent. So if we hold an inquest we will look into the circumstances and we will make a finding as to a person’s intent, if it is a case of self-harm. The point I am making is that unless there is an inquest we will not make a coronial finding as to the intention of the deceased.

I am sure you will have heard from my colleagues, and you will know yourselves, that for some deaths it is highly likely, just looking at the cause of death, that there was intent. If the cause of death is given by the pathologist as neck compression due to hanging, then it is likely that it is going to be a suicidal death. With others it is far more ambiguous. Single motor vehicle accidents and mixed drug toxicity deaths are deaths where there really is a possibility of suicide—even the death of a man who was a known diabetic who had managed his condition for 20 or 30 years and who one day decided to go off in his van without any food or insulin and was found about 24 hours later dead in the back of the van with no suicide note. The circumstances in a case like that are highly suggestive of suicide, but there would have been a finding in that case because there was no inquest. The finding would simply say something like pneumonia, because that was what caused that man’s death. It would be impossible to know from that finding that the man was a diabetic who had controlled his diabetes for many years and one day had suddenly decided not to do that.

It would be impractical or impossible for us to hold an inquest in relation to each of the possible suicides that take place in South Australia every year, because we have the capacity to do about 50 to 60 inquests per year and we have 1,800 reportable deaths. We must conduct an inquest into a death in custody; that is prescribed in South Australia, as it is in every other jurisdiction. Our remaining capacity is to be distributed amongst those cases where I, in my statutory discretion, consider it to be necessary or desirable that there be an inquest. That leaves a relatively small amount of inquest time to spread amongst the other social benefits that might come out of holding an inquest in a particular area—for example, industrial accidents and matters of that kind; road trauma, if you consider that subject; medical misadventures and so on. There is a wide gallery of other material that requires a coroner's attention and the input of the court, and even if you devoted your time to nothing other than possible suicides the maths is that in South Australia I think we have statistically reported in the ABS just over 200 suicides per year—somewhere around that. That has to be an underestimate. You can see that it is simply not a possibility to inquest each and every one of them; it cannot be done.

I know that in some of the other jurisdictions—you will have heard this—they do what they call 'chamber findings', which involves a desktop analysis of the material that is available, to make some kind of commentary and finding about intent. My feeling is that that is obviously going to give you more accurate data than you would get out of the system in South Australia, but it requires more resources than we have available in South Australia for what we do. In my view it still would not be capable of ferreting out every single case of suicide. For example, there might be a single motor vehicle accident without any suicide note, but if you delved a bit deeper you might find that the person had had a gambling problem or something of that kind. So these things might or might not come to be known, depending on who the police happen to speak to and what those people have to offer—and obviously people have different motivations for saying different things to the police about next of kin in the case of a sudden death. They might feel guilty and not want to relay material that might be suggestive of suicide or they might want to deflect attention from that possibility simply because they do not want the stigma attached to it.

That is a really broadbrush picture of what we do here in South Australia. I am very happy to answer any questions or to elaborate, if you want me to.

CHAIR—I suspect people will want you to elaborate and will want to ask you other questions as well.

Senator MOORE—I could not help but look at the last thing on your very brief note here, your disappointment that the study that had been instituted in your office had not gone forward.

Mr Johns—This is my annual report?

CHAIR—An extract.

Senator MOORE—It is from the annual report. It talks about the research done by Ms Rosenfeld. I am wondering whether you would like to put something more on record. We have the South Australia government here later this afternoon so we are happy to ask that question then as well.

Mr Johns—Actually, I have that page open. I was going to run through it. I take it that all committee members have had the opportunity of reading it?

CHAIR—I have marked it so that if it did not get asked about I would ask the question.

Senator MOORE—I have to admit I have not read your whole annual report, but I have read the page with that on it.

Mr Johns—That is all right. This is obviously pertinent. I have been acutely aware from the beginning of my tenure as the state coroner that my office holds a body of information about suicide which simply is not being analysed or exposed in any way, and I have had conversations with various health officials. I should say that I have not touched on the NCIS issue. In South Australia we have a clerk, an ASO2 in the parlance—most of you would know that that means a pretty junior clerical officer—who has the responsibility of coding data into the NCIS system. They do that with files as they come in initially. They have to do it in pretty good time; they are under a fair bit of pressure. They will code self-harm or suicide if it is obvious, which would usually be if the police have said something that suggests that it is obvious. They clearly are not picking up all of the other cases, which involve mixed drug toxicity or single motor vehicle accidents and some of the more ambiguous causes of death, and for that reason there is simply no way that in South Australia we are accurately recording via the NCIS all the suicides that occur.

I do not know whether you have touched on the question of the Australian Bureau of Statistics, but once upon a time, I understand, the ABS would go into coronial offices and review the files themselves and make some analysis of them. That now does not happen because the ABS has assumed that the NCIS data is a substitute for them doing that. At least in the case of South Australia—I can speak for South Australia only—I can confidently say that there will be suicides taking place in South Australia that do not get coded as suicide in the NCIS database. That means that we are underreporting.

That seemed to be me to be a pretty important piece of information that I ought to make known to the people who are in a position to make decisions about resource allocation and so on, so I have passed that information through in my various meetings with health officials and others. I made it plain to the health officials that, if they wanted access to material in coronial files, I was only too happy to facilitate that as long as we could work out proper protection of privacy of individuals and protection of the coronial process so that investigations would not be prejudiced if information were to leak out to somebody that might then alter their story or that kind of thing—typical investigation protection type issues.

Following those discussions, this little project involving an epidemiologist called Ellie Rosenfeld was instituted. She came in and spent a day a week for less than a year, as I recall, and she looked at some historical files. You would have to say they were historical. They were not enormously old. I think they were from a couple of years prior to the time that she was in the office. They were all what we call closed files. Then she analysed those documents and produced a really useful piece of work, which I think is the subject of some discussion between her and some other people about possible publication. It has all been de-identified and it would probably be a piece of work that the committee might find beneficial. But it is not mine to hand over. It is a piece of work that is, I guess, owned by the department of health.

Unfortunately the funding came to an end and the work stopped. In the time that Ms Rosenfeld was in the office, I would have been happy for her to have had wider access to material that was more contemporary, but her workload was too much and she did not have enough time to mine the data to the extent that you could mine it.

It arose out of the fact that there is a body of material, which happens to be held in the coroner’s office—and that is because the coroner is like the narrowest part of the funnel where all of the data should eventually end up—and it is all contained in one file. Some investigations are more thorough than others. It depends on the individual police officers involved in particular cases and so forth. Nevertheless, there is a volume of data which we hold, which, it seems to me, does not get used for any purpose once we have made a finding, simply saying, ‘Cause of death, neck compression due to hanging.’ But all of the other material in that file that may be of benefit to decision makers, health professionals, epidemiologists, or whoever, just goes off into a compactus somewhere.

Senator MOORE—Ms Rosenfeld’s project was in 2007?

Mr Johns—Yes.

Senator MOORE—That was when it closed cases but, since that time, there has been no further analysis of any findings?

Mr Johns—No.

Senator MOORE—Do you know, in your work across the jurisdictions with other coroners—and I do know you talk, which I think is very valuable—whether there were similar projects in other states?

Mr Johns—I think similar work has been done in some other jurisdictions. I have not discussed that subject with my colleagues, but I have heard that similar work was done. This is ad hoc stuff. When some little pot of money happens to be available somewhere, someone says, ‘If you want to come and do some work then that would be a good thing.’ One thing that surprises me a little bit, from the observation I have made—for what it is worth and it may not be worth much—is that there seem to be a number of NGOs involved in suicide prevention. SPA seems to be doing very good work. I would not in any way be critical or make any pejorative remark about NGOs—I think they are great—but it is a bit surprising that a matter as important as suicide prevention in Australia seems to be the province of NGOs rather than the province of mainstream government departments at the Commonwealth level. I thought it would be front and foremost in the minds of Commonwealth mainstream government departments—presumably, the Department of Health. I do not quite know why that is, but the gathering of the material and data about suicide prevention and the initiatives that are currently being pursued are being pursued, admittedly with Commonwealth funding, by an NGO. It seems a bit surprising to me.

Senator MOORE—We have Professor Webster talking to us this afternoon. He is head of the advisory council, which advises the minister. I am interested, because your point about the clarification of data and looking at intent, which would be my understanding of what Ms Rosenfeld’s project was looking at—looking at things which were uncertain and trying to work that at—seems to be something that many people are talking about in terms of statistical clarity and also providing more information about exactly what the motivations are so that people can look at how we can address that. All the submissions have various forms of that. We will ask Professor Webster whether there is any national approach to that, because certainly we have had the issue that every coroner's office, whilst having a clear similarity of purpose, have variation of practice and that trying to pull together a national picture is very difficult, not because of lack of goodwill and interest but because of all the other things that happen in doing the job and, as you have mentioned, a lack of resources.

Mr Johns—And differences in jurisdictional approaches.

Senator MOORE—Who does it and at what levels? We will try to get hold of some of Ms Rosenfeld's work and see what the background to that was and see whether there are similar things. It seems that this committee is struggling with that paragraph as to how we get this organised.

Mr Johns—It is a snapshot from a particular period, but it was really worth while. Far more needs to be done than just that little bit of ad hoc—

Senator MOORE—One day a week, looking at a period that was uncertain and all those things.

Mr Johns—One thing that comes out of all this is that coroners may not be the ideal people to bring together the work and the data. I am not putting this very well but, when a coroner makes a finding about intent, to those people who regard completed suicide as a negative—of course it is a negative, but as a stigma that brings shame on a family, it means that various legal principles come into play about the burden of proof. It seems to me that that may not be the test that public administrators who are responsible for distribution of resources ought to be applying. Maybe you need to have another process which hinges off—it seems that the coronial data is probably the best, most complete repository of data that you will get. If you enable access to it by another functionary, they would then have an approach in reaching a decision—'Yes, I'm going to classify this one as a completed suicide,' and by this I am not saying it should be done by an ASO2 who has never had any training in anything apart from word processing and spreadsheet stuff. They are great people, they do a good job but—

Senator MOORE—But they are not making an assessment? They are translating—

Mr Johns—They are not making an assessment and they cannot make an informed assessment. I think you really need to have someone who is able to do that. Then that data can then obviously be de-identified. Maybe there need be no stigma that ever becomes public—I use the word 'stigma'—I say that not because I personally regard suicide as a stigma but, for those families who are sensitive about that issue, that could then be recorded in a way that accurately caught the data but without anyone ever thinking that Uncle Fred committed suicide. I do not know whether that has been suggested by anyone else, but it seems that that would be a solution to some of these problems and then it could be made uniform across Australia.

Senator ADAMS—Thank you for your very informative presentation. It was really good. I am from Western Australia. I note that you are the national president of the Asia-Pacific

Coroners Society. Did you, within that society, look in any way at the cost of suicide in Australia over that time?

Mr Johns—No. As a society we have very limited resources. For example, there is no executive, no ongoing secretariat or anything of that kind. Our principal activity is to organise a conference once a year, when we try to cover a number of subjects, including suicide. I organised a conference in Adelaide, in I think 2008, at which Professor de Leo and Caroline Aebersold from SPA presented. They presented to us on the disparate approaches of the various coroners and how there would be benefit in getting more accurate data. The society is not a body that conducts research or anything of that kind; we organise a conference once a year for coroners and that is it. It is certainly something that could be developed, with the resources that we have to put into it, which are basically people's own personal annual contributions. It is little more than a shell. It has a lot of worthy intent and I am not derogating from it in any way. It also tries to reach out and embrace Pacific countries, such as Papua New Guinea, and assist with the development of coronial work in some of the Pacific island countries as well. It has a pretty broad focus and it is a continuing education kind of society. But it does not have a research capacity.

Senator ADAMS—With the issues that are raised at the conference, you are trying to get topics of interest and things that are actually affecting everybody in their day-to-day work. As far as the coroners are concerned, where would the actual issue of suicide fit in that?

Mr Johns—It is very high on the agenda and I do not think we have had a conference when suicide has not been a topic and particularly, in recent times, also the subject of the different approaches and the need for accurate data across Australia. I think all of the coroners would agree that that is certainly not happening at the moment. There seems to be some difference of emphasis amongst people about what benefit may come from gathering that data. My personal view is that if you have the most accurate data then that builds the strongest case for resource allocation and, when there is doubt about it, your case is weakened in some way. So you should be proceeding with the best information possible.

Senator ADAMS—I would certainly agree with your statement. I do not know whether you can answer this question, but I will ask it. Could you give any estimate of the number of deaths through the documentation that has come through, without the constraint of the act and the way that you can report? What we are told, by the data from the ABS, is that this is wonderful news: suicide rates are dropping. And yet, from the evidence we have received to date, we would query that just from what you have said, that the system actually frustrates the real story behind this. Once again, with mental health services, it has such long-reaching areas into the population as to how this is recorded.

Mr Johns—I probably do not have the statistical qualifications and knowledge to quantify the extent of under-reporting, at least in South Australia. I believe that it is significant. I do not really want to commit myself, but I think it is at least in the order of several per cent; it might be up to five per cent under-reporting. That is a pretty wild guess based on 4½ years of reviewing every file in South Australia that comes through and looking at some and thinking, 'Well, this is suggestive to me of a suicidal death.' But I know it has not been coded that way. I am not an expert on stats and so on and so forth and I have not done the exercise of sitting down and totalling it all up. That is really a gut feeling.

Senator ADAMS—I think there is a frustration about this throughout Australia, and that is one of the reasons that this committee is trying to look into this and to see where it is going. It is confusing. Everything is improving, so once again the funding disappears to another area because maybe you have solved that problem, when underneath we think it has not been solved.

Mr Johns—Some people might argue—and I think they do—that if you have got an under-reporting you still have a base of some kind from which to make comparisons. So if there were an under-reporting 10 years ago and there is an under-reporting now, you can still work out a trend. I think that is pretty fraught because if the data is not very accurate then it is not very accurate.

Senator ADAMS—Say somebody has arrived at an accident and emergency area and they have not been able to be seen if they have been a self-harmer or something like that—they have been pushed to the side and left—and then later on they have gone off and unfortunately taken their life. Have you had any evidence of that at inquests—that a person had been troubled and tried to seek help but was turned away?

Mr Johns—Over the years we have certainly tried to look closely for any evidence of contact with the public health system or the mental health system in people that commit suicide. You will see different levels of performance. You will see some cases where what you say regrettably does occur. You will see other cases where there has been some intervention. Maybe the person has been resistant to receiving help and has not been helped. We look for that. Because of the resources that we have available to us, I suppose it is the most egregious of those cases where we will go to an inquest. There will be cases where you think that there was some attempt made to follow up by community mental health services or services of that kind but the person was resistant to that or apparently resistant to that on the information that is available to us. You might then think, ‘We have to draw a line in the sand on this case now’ and move on to the next case. That is the sad reality.

Senator WORTLEY—Thank you, Mr Johns, for making the time available today to appear before the committee. On the issue of the statistics you have said that you cannot clearly give information regarding the number of unreported suicide. What do you feel would be the consequences of having unreported suicides in relation to perhaps the work of this committee?

Mr Johns—I think an under-reporting means that public decision makers who are responsible for resource allocation are making decisions that are based on inaccurate data and it does have the potential to perhaps distort those decisions. It cannot be a good thing. If I am correct in my understanding of what used to happen with the ABS, it may be that the ABS data was more reliable when they actually went into coronial offices themselves than it is now when they are relying on NCIS data. But I am speculating; I do not know. It seems to me that we have got a disparate system across the country. We seem to have the job being dealt with by an NGO and I wonder whether it could not be done in a more thoroughgoing way.

Senator WORTLEY—The submission that we have before us says that 167 deaths were coded as suicide in South Australia in 2007-08. In your opening statement I think you mentioned around 200 being the figure. How easy is it for you to access information in relation to South Australia—perhaps, say, for the last five years?

Mr Johns—It is very difficult because we have not recorded any of that data. You have mentioned a particular year. I think if you look at other years you will find that the number is probably higher. I am not, in coming here today, purporting to have an accurate idea in my head of the actual numbers. The point that I really want to make is that the number is significantly higher than the ABS data would suggest. It seems to me that the public is simply not aware of the prevalence of suicide. I think that the Australian of the Year, Professor McGorry, made an observation which really hit home with me because it is something I have thought too, which is that as a society we devote a lot of attention to the road toll—and rightly so; I would be the last person to say we should not do everything we can to keep that low—and that is constantly in the public spotlight, but there would be double the number of suicide deaths in South Australia, or close to it, than the number of deaths on the road. Does the public know that? It seems to me that the public does not know that. If the public did know that then they might be disturbed sufficiently to agitate for more effort to be put into suicide prevention.

Senator WORTLEY—This question will touch on the area that you have just mentioned. From what you have seen in your work, is there an age-specific group or is there an increase in any particular age group of people who commit suicide?

Mr Johns—Not really. Every one of these cases is tragic. Some cases sometimes seem more poignant than others. The very elderly who commit suicide are, to me, some of the saddest, because these are people who presumably are making a decision to end their lives because things have just reached a point where they cannot bear to go on any longer. They often die lonely deaths. I think they must be very frightened as they are doing something which is very confronting and jumping into the unknown. They are very vulnerable, elderly, frail people. I have seen the case of a 92-year-old gentleman hanging himself in his shed after having an episode with a demented wife who he was probably unable to cope with any longer. Maybe some public attention directed to those things would raise public awareness. Youth suicide is obviously also a terrible thing, but, as to prevalence across any age group, I cannot add anything other than to say that it is not really confined to any particular age group. I think the statistics are fairly plain that men in particular age groups in middle age are probably more prone to it than other groups.

CHAIR—They are more likely to complete and women are more likely to self-harm.

Mr Johns—Yes. But it requires attention across all age groups, I think. Some of those very elderly ones raise a totally different subject, of euthanasia, and I will not even go there.

CHAIR—There is a comment at the end of the short piece we have got from the annual report, around intent and the Coroners Act. It relates to the comment you made about whether you have an inquest or a finding. This is a two-part question. One is: do you think the South Australian act should be amended so that you can talk about intent when you are reporting findings—‘findings’ is the right word, rather than ‘inquest’, isn’t it?

Mr Johns—Yes.

CHAIR—And would you like to see uniformity across the coroners acts across Australia so the manner in which deaths are handled is consistent across Australia?

Mr Johns—That is a really difficult question for me to answer. The reason is that a jurisdiction like Queensland, which is such a huge state with a number of large regional centres, has a system of far greater decentralisation of the coronial system than, say, South Australia does, which means that you necessarily have to have more people involved in the process in Queensland than you do in South Australia. That carries with it the risk that you are going to have different approaches to determinations of intent with the more people you have got involved in making those kinds of decisions. Because it is being done in a judicial process, the approaches might differ from person to person.

If what we are trying to achieve is to get the best possible data, there might not be that much to be gained by trying to fix and make uniform the coronial approach. Having said that, I cannot see for the life of me why in Australia we do not have the same approach to the coronial system in every jurisdiction. Logically you would, but that would require some pretty robust discussions about resources and how we are going to deal with that. Without assurances that those issues are going to be addressed, changing the law will not really make much difference. You have to change the systems as well and have them be similarly resourced across the jurisdictions.

CHAIR—It seems to me that this is not just about the numbers; it is about the intent and what, as you mentioned, led up to somebody taking their own life or contemplating taking their own life. Those are the issues we need to deal with.

Mr Johns—Absolutely. I suppose the starting point is to work out what it is that you are trying to address. If you are not even doing that, then the subsequent analysis of each of those cases—I am not saying that you do not analyse the cases; you do—

CHAIR—I was not implying that you were not.

Mr Johns—I am sorry—I could be taken as suggesting that, because I have been placing so much emphasis on capturing the data. That is really because, if you do not capture the data in the first place, you do not even know which files to look at. If someone came into my office tomorrow and said, ‘Here’s a big resource that’s going to be available to do all of this stuff,’ then I would say, ‘Wonderful.’ And if they said, ‘Show me the files,’ I would say, ‘I can’t. You’re just going to have to start at the beginning of that box over there and then work your way right around the room through all of those filing cabinets and look at each one,’ because we are not capturing that group to begin with. I agree that you must analyse each one beyond that. You analyse it according to the purpose that you want to put the results to. You might want to have an epidemiologist analyse it, or a psychiatrist or a psychologist or people with different skill sets who might be able to bring different conclusions to bear. As I said before, gathering that data in the first place and then channelling the files that underlie the data through to people with the right skill set might be something that is better dealt with as something sitting alongside the coronial system but not actually done coronially. That is not for lack of concern or desire to assist or anything else; it is just my thought about what might be the best solution.

I do not know if you have had any contact with Professor Goldney in South Australia. He is an eminent psychiatrist here. He and I have had some discussions over the past year or two about the issue of public perception that suicide is not as prevalent as it actually is. We have talked about the media’s role in reporting on suicide and how that might be enhanced. We have touched on the question of media fear of setting off a copycat domino effect if they do broach the subject, and various other things. At one stage he and I were tossing up the idea of a toll, like the road toll, which seems to bring the public’s attention to bear so much on what is happening with road deaths. But that, in itself, might risk copycats and so on. Even Bob Goldney did not seem to have the answers!

CHAIR—Yes. We are struggling with it as well. It has come up time and again.

Mr Johns—He is a good person you might wish to get a submission from.

CHAIR—Okay. Thank you very much. Your time is very much appreciated.

Mr Johns—Thank you very much for hearing from me.

CHAIR—As you can see, there is a great deal of interest in the issue.

[10.05 am]

FAIRWEATHER-SCHMIDT, Dr A. Kate, Research Fellow, Freemasons Foundation Centre for Men’s Health

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

Dr Fairweather-Schmidt—Yes.

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

Dr Fairweather-Schmidt—Thank you. By now, I expect, you have heard many submissions highlighting the critical issue of suicidality in the community, both fatal and non-fatal. In particular, male suicidality is a pressing problem—particularly so, as the methods of attempt are generally more lethal than those chosen by females. As a consequence of greater lethality, male suicide death accounts for 75 per cent of all suicides and associated costs. Among males, suicide is the leading cause of premature death that accounts for 9.8 per cent of potential life years lost. And these deaths are avoidable and have exceedingly detrimental effects on families and society, including, of course, economic effects.

The Freemasons Foundation Centre for Men’s Health advocates that male suicidality is considered an issue of national high importance. A specific focus on research and intervention and prevention strategies would afford greater understanding of the factors preceding suicidal behaviour, enabling more targeted approaches that current strategies are acknowledged as lacking.

Work that I have undertaken, both as a Freemasons Foundation Research Fellow at the Freemasons Foundation Centre for Men’s Health and as a visiting fellow at the Australian National University with my colleagues at the Centre for Mental Health Research, is included in only a small number of population based studies on suicidality. And the benefits afforded by adopting a research program focusing on non-lethal suicidality is that there is a capacity to track factors associated with suicidality, providing greater opportunity for information-gathering and capacity to build intervention and prevention programs based on these findings.

Research undertaken thus far demonstrates that gender and age influence factors relating to suicidal outcomes. However, uncovering the underlying mechanisms remains a research challenge. An investigation my colleagues and I conducted sought to examine whether suicidality was associated with depression in a way that is similar to the relationship between depression and anxiety—that is, they frequently occur comorbidly but exist as two separate syndromes. The nature of this relationship was important to determine as it has implications for the way that suicidality is assessed and, potentially, prevented. Our findings highlighted that, similar to anxiety and depression, suicidality and depression were independent but strongly related, too.

Of further interest was whether the strength of the relationship between suicidality and depression remains stable across differently aged people or between genders. In the course of the investigation it became clear that the relationship between depression and suicidality did not meaningfully differ among participants at different life stages—for example, aged in their 20s, 40s or 60s—or between men and women. The key issue is that this research underscores that the decrease in non-fatal suicidal behaviour in older people is unlikely to be due to a change in the association between depression and suicidality. It is probable that the variation in levels of suicidality across life span and gender reflects the differential distribution of risk factors such as the ages at which people encounter specific stresses like employment difficulties, relationship issues, retirement and illness.

While this research has to a small extent explored the relationship between depression and suicidality, there are many factors yet to be investigated. This further highlights the necessity for the support of research specifically addressing questions that would provide information relevant to future intervention and prevention activities. This study is illustrative of the need for a nationally funded research program which accommodates age and gender differences. It is needed as a matter of urgency to address the following questions: what are the specific factors that exacerbate or attenuate the likelihood of experienced suicidality, including ideation and progression to attempts? How do these factors operate in relation to the suicidal process? Do they have distal—far reaching—or proximal—closer—relationships to the suicidal act? What role do gender and age play in this process? How do age and gender influence the action of other risk factors? What are the underlying mechanisms that link gender and age with factors associated with suicidality?

Founded on a body of robust research findings, including the aforementioned questions yet to be investigated, we would promote the development of a public awareness campaign focusing specifically on male suicide, highlighting the significance of the problem and age and gender specific risk factors and where men can seek help. It appears that most people are still unaware of the issue of male suicidality as most of the attention in recent years has been focused on youth suicide. While efforts have been made to raise awareness of male depression and anxiety, the study I have described suggests that suicidality can occur independent of depression and anxiety and so requires a separate campaign. Social psychological theory is best placed to guide the manner in which this campaign is structured. It indicates that information is internalised more effectively if the messages are tailored to be relevant to various reference groups. For men, these may include sporting clubs or teams, fraternal organisations or perhaps professions. Importantly, group membership may be aspirational—that is, the individual aspires to be like others who are members of that group—and therefore members of the group may sometimes unknowingly act as role models.

We strongly advocate a national framework to guide the development of these programs and services to prevent male suicide. It must be based on a review of existing evidence about age and gender related factors that contribute to and protect from suicidality, including the evaluation of interventions that have been conducted internationally. We believe such a review would support the development of interventions in the following areas: support services for men experiencing significant life stress, especially relationship breakdown and employment problems, through telephone help lines and peer support programs promoted through government agencies in contact with men experiencing life stress. Generally men’s social networks are not as well developed as those of women. During relationship difficulties or breakdown, men are often isolated as the social contact is frequently founded on the social network established by their spouse or partner. This functions to leave men isolated and without support networks, which are particularly pertinent during such stressful times. Further, social contacts that men do establish often involve work colleagues. If there are work issues that perhaps lead to unemployment, the social network becomes much less accessible. This results in greater isolation, which is a known risk factor for suicidality. We need to improve depression diagnosis and treatment for men which is also age sensitive, recognising that men's experience of depression is different from women's and that age based variation also exists, and that impacts treatment efficacy if the target approach is not adopted.

There should be depression and suicide screening separately for the seriously ill, recognising that a physical ailment significantly increases the risk of depression and suicide and again provides an opportunity for targeted intervention. Being dependent and incapacitated is often an exceedingly difficult situation for men to adjust to psychologically. However, these are exactly the characteristics that physically ill men are forced to adopt to. This throws up emotional challenges and often practical challenges too. During these times, support is pivotal to men's capacity to cope but, as highlighted previously, the social networks are often not well established or accessible away from their workplace.

Finally, we need emotional literacy for boys at school to increase the capacity of boys to understand their own and others' emotions to meet their own and others' emotional needs. This is not an area of my expertise, but it requires more research to determine whether it has efficacy in a pre-emptive capacity.

The Freemasons Foundation Centre for Men's Health thanks you very much for considering our suggestions and we would be happy to assist in any manner we can to move forward to prevention of suicide and intervention in suicidality.

Senator MOORE—This committee has a long history, through a range of inquiries, of considering the need for more focused and community engaged research, so that part of your submission is something on which we engage immediately. From your own experience in the field is this the kind of work that the NHMRC or the ARC have taken an interest in before?

Dr Fairweather-Schmidt—I do not have very long experience, but it is certainly research that I hope to put to the NHMRC and the ARC because I think it is of huge importance. Age and gender is such a basic thing, and I think it describes a lot about society and the things the various age groups grapple with. If we do not target it in a way that makes it relevant, it will miss the target. It will become just another message that is not really targeted to me. If I am feeling depressed or suicidal, I have so much on my mind that a message that is not really targeted to me is going to fall short. You need to have something that feels truly relevant to that person.

Senator MOORE—We have heard a lot of evidence in this inquiry and there are two groups in particular that I would like to see whether you are aware of. One was a group that looks at men's health and their issues in the workplace, particularly on building sites. That is a group called Ozcare, in Queensland. They spoke to us in both Canberra and Queensland about their work with men involved in the construction area and the range of issues that impact on their health. They look at their emotional health as well. The other group that gave us an engaging piece of evidence was the Men's Shed organisation. They spoke about the way they were addressing the issue with men. In the work you have been doing, which covers such a wide range of issues looking at men and their needs and their different ages in society, I was wondering whether those two groups had come to your attention.

Dr Fairweather-Schmidt—Actually, no. That is not to say they are not very good. The type of research I have conducted is very epidemiologically based. It is broad strokes research that looks at men’s self-reporting on their emotional and demographic situations. From that we can derive information about various issues that face various age groups. For instance, amongst young men, the issues tend to revolve around identity and relationships, which makes perfect sense. For men in their 20s this is a time when they are trying to construct who they are. They are often having to deal with work issues but also issues at the heart, emotional issues, which are new; they are gathering life experience.

As men get a little older, say in their 40s, they often have families who rely on them, so economic issues are really important. As well as juggling family issues, which are taxing to say the least, if they have employment issues, that places them in a very stressful situation. If you are not in a good space, that exacerbates things. People know that men’s symptoms of depression are different from women’s. They are often irritated and cannot process information very well, so their interactions with their family are often not very easy. If they have pressures from work on top of that, it makes it very difficult for the male to operate and also for their family to support them. In a very stereotypical way, men are not communicators first, and that makes it difficult for interaction.

When men get into their 60s there is another lot of issues, including leaving work and ill health. Often their work characterises who they are, so, if they are not working, who are they? In a very broad and general way, men have always made things happen, so when they have to deal with issues of ill health they cannot be the movers and shakers; they have to be dependent. They cannot make things happen because they cannot make themselves better. So they are in a very different role and that is very stressful. Ill health is stressful anyway, so it is very difficult and isolating to be placed in a role that is completely different from the role they have lived for their whole life.

Senator MOORE—Your submission was fascinating and it engaged me immediately. Is the Freemasons Foundation Centre for Men’s Health providing you with support to continue the research?

Dr Fairweather-Schmidt—Yes.

Senator MOORE—Is that time based? Is there a time when that funding is going to end? You do not get funding through the NHMRC process or any of those things. What is the future of the work you are doing?

Dr Fairweather-Schmidt—My initial appointment is for three years with another two years continuing. If all bodes well, there is another three years after that. I very much hope there will be funding to continue my work after that, and that would be looking at the national funders.

Senator MOORE—Would it be a breach of a contractual arrangement to tell me how much that research is worth?

Dr Fairweather-Schmidt—I cannot tell you. I do not know what that would be.

Senator MOORE—It would be useful to know how much we are talking about in terms of the overall budget. Thank you.

Senator ADAMS—Thank you for your opening statement. Have you done any study into rural and regional areas?

Dr Fairweather-Schmidt—I have not. The dataset I have engaged with up until now has been focused in Canberra. It is a dataset called ‘PATH through Life’, and its participants are drawn from Queanbeyan and Canberra. They tend to be not exactly representative—they are not far from it, but they are not exactly the same—and they are not regional by any shot.

I know that there are very specific issues that need to be acknowledged in rural and remote areas because they have a whole lot of different pressures and access to mental health services is terribly difficult for them. However, I do know that the Centre for Mental Health Research is putting a lot of effort into online services. But that relies on a person’s feeling of comfort in dealing with obtaining services that way. It is a very personal thing whether people want to sit down and talk face to face or whether they want to remain somewhat anonymous, which is also a benefit, and gain their information from an online source. It is well known and well acknowledged that there needs to be much more research in the bush.

Senator ADAMS—You would have heard us asking Mr Johns about the statistics and about the ABS and their data and the conclusion drawn that suicide really is decreasing, so therefore unfortunately a lot of the funding is moving away from that area, and then the difficulties in how the coroners have to record things due to their different legislative areas. Have you got any idea, in what you have been doing, about the cost of suicide to the community? I notice that you have quoted in your submission the New Zealand study. Would you like to talk to us a little bit about that? The figures are huge. If this is accurate, it is an enormous cost.

Dr Fairweather-Schmidt—It is. I must indicate that the submission was drawn up by another member of the centre, so some of the information that she has included I am not well versed in. However, it is a huge amount, in the millions. If I can just go back to the earlier part of the question, the expectation that suicide has decreased, aside from the coding issues that Mr Johns was talking about there are other issues to do with measuring suicidality that have a huge impact as well. I did a study that is on the way to being published. I am not sure if you are aware of the national survey for mental health, but my study compares its rates of suicidality, attempts and ideation, not completes, and those measured in Canberra with the PATH through Life survey. There was a huge difference. I think the suicidal ideation prevalence for 12 months was about 3.8 per cent. PATH found 8 per cent.

While there might be more suicidal behaviours in Canberra, it is more likely to be an artefact of the way the information was gathered. The national survey used interviewers to ascertain information and, whilst the method in which that was done is internationally standard, the way that PATH through Life gathered the information was through a palmtop computer. We had interviewers but the participants actually responded to questions on the palmtop computer, so there was no interaction with the interviewer at all. The items that they are asking in these sorts of surveys are often really personal and often stigmatised. So if you are sitting there responding to someone about a very personal and possibly stigmatised syndrome, you are going to be erring for the most part on the conservative side. I think that it is really important to be mindful about the way the information is gathered, and the PATH through Life survey gathering information on the palmtop computer basically anonymised information aside from their participant number, which means that they could respond more freely to the items without concern for the interviewer making a judgment about that person.

There are other issues to do with data collection aside from just that one. It is a huge impact on the statistics that you gather. Professor De Leo, whom Mr Johns spoke of, has also discussed this issue. Aside from the statistics that it brings up, the comparison between other studies in different places within Australia or internationally cannot be conducted properly without having consistency about how that data is gathered. So there is a lot of distance to be covered to make sure that information is gathered properly. That is one of the reasons why I stuck with PATH for quite some time, because I can actually publish information that is consistent across time. They are doing a longitudinal study and are up to their third wave, so it is about 12 years now. That is an important issue.

Senator WORTLEY—In relation to the age groups, does your research cover adolescents as well?

Dr Fairweather-Schmidt—The age groups begin at 20 years. Whilst some people consider 20 as still somewhat adolescent, it is not strictly adolescents. I think it would be great to have some more information about what is happening in adolescence based on issues that have been brought up previously in suicide prevention.

Senator WORTLEY—In relation to what we heard from the previous witness, I think you were here, when he was talking about the elderly, could you touch on your understanding of what is happening in that particular area?

Dr Fairweather-Schmidt—Interestingly, even though the non-fatal rates are quite low, about two per cent ideation, and attempts are even lower, very low, completes, especially among older men, are quite shocking. The reason is, as you may have heard previously, that often the older men are not interested in communicating anything about their suicidality, they are just wanting to stop.

Senator WORTLEY—Is there a distinction between perhaps someone who takes their life as a result of depression and loneliness or an issue as opposed to someone who takes their life because of a terminal illness?

Dr Fairweather-Schmidt—Some years ago I would have said yes, but I am not so sure now. You can do it statistically, but you cannot actually take out the impact of a chronic illness. Also, if you medicate elderly people with antidepressives, then often they improve in their outlook. A lot of suicidality that is experienced is probably related to a depressive syndrome. That is not being picked up because they are old. People just say, ‘Oh well, they’ve had a life. It’s pretty rotten living in a nursing home and not in your own house and having limited access to your family. Life is not that nice.’ They are missing some of the key issues about suicidality’s relationship with depression. A lot has come up in the past about the nature of life for the elderly, especially in nursing homes. Life is pretty unhappy for a lot of them and pretty uncomfortable too. People think that is a great way of justifying why people are suicidal at that age, because it is pretty hard yakka.

CHAIR—I have a couple of issues to follow up. One is the issue around the work that you were talking about regarding the starting point of around the age of 20. I wonder whether any work is being done on young people who had suicidal ideation. I take on board the issues around risk factors at different ages and wonder, when somebody had ideation as a young person, what is the link with other risk factors as they age?

Dr Fairweather-Schmidt—If they have had instances of suicidal ideation as a young person, there is more likely to have been some other risk factor that predated that. Suicidal ideation or suicidal behaviour does not pop up on its own; it is as a consequence of some earlier experience. That happens in everybody. There needs to be a previous risk factor that happened to set up the conditions. What is generally accepted is that those risk factors happen, say, in their childhood or some time much earlier than the suicidal instance, it is not enough to produce suicidality by itself. There usually needs to be a trigger that happens fairly close to the suicidal behaviour. Risk factors could be either environmental or intrapersonal. Some people just have a greater likelihood of being depressed, anxious or more reactive, or it could be that something happened to those people—abuse or a traumatic event—that sticks with them. Their personality and the way that they respond to the world will influence a lot as to how they manage that type of incident early on. Some research that I have done looked at what distinguishes people who have ideations and those who go on to attempt. There is usually no real difference in their earlier life. What makes the difference between those who ideate or remain ideate and those who go on to attempt is recent things in their life—whether those are relationship problems or work problems. Classic for men in their forties are employment issues. It increases their likelihood of attempting by about ninefold. It has a big impact. What I am saying is that suicidality does not just appear; there has to be something before that.

CHAIR—Regarding young people in particular who have self-identified or been identified through existing support—without going into the issue that we know we need more—the case then surely would be to continue offering age-relevant support for those people if they have already had ideation. We know that is a risk factor.

Dr Fairweather-Schmidt—Definitely. Once they have had ideation, their likelihood of going on to future ideation and attempts and/or completes is much increased. There is definite research out there to suggest that. Some research suggests it is kind of a threshold. The more that a person experiences these thoughts or these behaviours, the more it encourages their brain to follow those sorts of patterns, those sorts of coping mechanisms. It becomes easier to have those thoughts and behaviours. So I would say definitely those supports need to be there. Sometimes it is pie in the sky stuff, but it has to be there. We must try to offer these services.

CHAIR—My final question goes back to some of your earlier comments about targeting—as I interpret what you say.

Dr Fairweather-Schmidt—Sorry.

CHAIR—No, no. Obviously everybody hears different things. The point is about making sure the message is targeted to relevant age- and gender-specific groups. That is not exactly rocket science, when you think about what advertisers do in terms of targeting.

Dr Fairweather-Schmidt—It is not.

CHAIR—This committee did several inquiries into alcohol and the targeting of alcohol messages through advertising. It was very clear that alcohol—alcohol is just an example I am thinking of because we have looked at it—is targeted at specific audiences very clearly. If we can do that to sell products, surely we should be taking that up in terms of targeting our messages. Is the point you are making that the messaging that is being done at the moment—because there are some programs, like beyondblue, that have some clear messaging, particularly for men—is not being targeted enough? Is that the message I take from what you are saying?

Dr Fairweather-Schmidt—I was not necessarily pointing any fingers at anyone.

CHAIR—I am not pointing at them, but I am using them as an example.

Dr Fairweather-Schmidt—Okay. I would say the more the better. We need to make it specific so that men—but also women—that are suicidal get the message and they get the message about where they can get support and that it is relevant to them and that the issues that are spoken about in the message really are true to them. It is something about identifying with that message that actually seems to motivate people, and feeling like that message is speaking to them and is not just a universal message that is going out to all and sundry. It is a very key issue to feel like you are being spoken to and you are important.

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

Dr Fairweather-Schmidt—My pleasure, and all the best.

Proceedings suspended from 10.43 am to 10.53 am

SHELDON-STEMM, Mr Mark Andrew, Chair/President, Kentish Regional Clinic

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

Mr Sheldon-Stemm—Yes, I have.

CHAIR—Thank you for your submission. I now invite you to make an opening statement, after which we will ask you some questions.

Mr Sheldon-Stemm—I wish to thank the chair and committee members for the opportunity to appear before you today. My role in the area of suicide prevention is with an NGO that provides a sustainable community empowerment and education program to mainly rural communities throughout Australia. While we are based in Tasmania, our programs are currently operating in Tasmania, Queensland, Victoria and South Australia. The best way of describing what we do is to call it a program of social inclusion and action based around the areas of suicide and self-harm. Our program completes a gap that exists in the current system—that of a first response for people at risk.

The Community Response to Eliminating Suicide program, CORES, currently has 22 programs operating covering over 60 communities. We have trained over 1,800 people in the skills to identify and prevent suicide, including 70 team leaders. We know through our network that it is normal for people to use their training within six months of undertaking the course. Currently we average between 300 to 500 suicide interventions per annum throughout these communities, covering a population of 150 to 200,000 people. These interventions are performed by people from all walks of life, with their utmost desire being to assist somebody in need. Our program is aimed at the ordinary person in the street as we have found they are in some way connected to everybody in their community and are best placed than anybody to identify the signs and signals of somebody at risk of suicide or self harm.

While there has been much spoken about mental health in this inquiry in submissions and evidence given to date, our program is focused on the emotional health of ordinary people. While statistics indicate the rate of suicide in Australia is around 1,800 people per year, we would estimate that the real figure is much higher than that. Therefore, we do not operate from a mental health paradigm and we maintain that the majority of people who complete suicide or are at risk do not see themselves as having a mental illness or have ever been diagnosed with one. Nor do people under stress or with poor emotional health identify themselves with the need to access mental health services as this is not the first port of call or to whom they signal their intent. Rather they link with their own communities, their family, friends and workmates.

The model we utilise to deliver the program provides a first response for someone at risk and the skills for community members to safely intervene and then connect the person at risk with the most appropriate services available. The model is a self-management system which allows the community to look after itself without the requirement of having somebody from outside to service it. The model is also fully self-sustaining financially and continues well after the initial set-up period.

In particular reference to this inquiry, we see two main issues impeding the reduction rate of suicide and self-harm in Australia. In our opinion the first is community attitudes. Until the general community and communities are engaged in an open and frank discussion about suicide and provided with the skills to recognise and act then very little will change. Money spent on more services will have a marginal effect on the rate of suicide. It is now time to support another focus to obtain a real change.

The second issue we see is the politics of suicide and the fact that the current paradigm from which services are delivered works for a minority, not the majority. It is our experience that, unless a service or program is delivered from the current paradigm, it is treated with suspicion and has limited access to resources and therefore the majority of people who require support are left without. I am not saying that less should be spent on the current system. In fact, it needs more to be spent on it. But there is a need to cater for the majority. One way of doing this is to provide an equal amount of resources and efforts in addressing community attitudes and skilling people to act at the moment that is most critical.

Lastly, I would like to draw your attention to pages 92 and 93 of our evaluation of the CORES program, included in our submission, where it states:

> … because there is a strong possibility the authors would have considered CORES to be a ‘best practice’ example of a sustainable community suicide prevention program.

Thank you.

Senator ADAMS—As far as your program goes, you obviously move around rural and regional areas?

Mr Sheldon-Stemm—Yes.

Senator ADAMS—You are talking about how we get the community to accept that suicide is happening in these smaller areas. Can you give us an idea about what your approach is when there has been a tragedy and you have been asked to come forward?

Mr Sheldon-Stemm—Any of our programs or initiations always come from the community. We have tried a couple of times to initiate things within the community, particularly through the Department of Health and Ageing, and those particular communities have not worked very well. In fact, one has been an abject failure. We find that if we have people in the community who are passionate about suicide and passionate about doing something and we have someone who is a champion in the community, those are the people who basically take the running. We supply the tools and skills for those people to move forward with that. So it is really about those people coming to us.

We have had a few occasions where we have had one or two people who are very passionate in a community who have come to us. When we have gone to the community, the community has had no sense of community itself, is not interested in dealing with the issue of suicide—is well aware of it, but basically has a head-in-the-sand attitude. We have had to say to those two or three people, ‘I’m sorry but we can’t do anything for you because our program won’t work here.’ Our program relies entirely upon the community taking control of itself and basically running it by itself. Most of our initiation with communities has come through our two ABC *Landline* programs in 2006 and 2008. We were shown nationally on ABC *Landline*, and we just follow up from there, and we continue to do that. We have 34 or 35 communities at the moment who would like our program, but we are unable to supply it due to no funds—they are looking for funds or funding is not available.

Senator ADAMS—The Department of Health and Ageing has funded six programs. Is that correct?

Mr Sheldon-Stemm—Six in Tasmania, yes. But we are unable to access funding in other states through DoHA.

CHAIR—Why is that? What has the department said?

Mr Sheldon-Stemm—I wish I had an easy answer for that. I have gone to Canberra, I have seen the bureaucrats in Canberra, seen the minister’s adviser in Canberra, but effectively they cannot give me a reason. They just will not fund it.

Senator ADAMS—Have other states asked for a copy of your program to try to do it themselves?

Mr Sheldon-Stemm—Yes. We have a program running here in South Australia at the moment, amongst communities on Eyre Peninsula. That is self-funded by the community. The South Australian government has refused to fund our program and we have made several attempts. One of those reasons might be a political reason because one of our strongest advocates is an upper house whip for the Liberal Party. That is my second point about the politics of suicide: unfortunately programs and so on do not get a run because of the fact that politicians get involved.

Senator ADAMS—You heard the evidence given by the coroner this morning and the questions asked of him as to whether the number of people who commit suicide are underrepresented. Do you think this might be the cost of suicide prevention? Do you think because the numbers are a lot smaller and the ABS data shows that suicide is perhaps on the decrease that the focus has been taken away and that could be the reason why it is not being funded?

Mr Sheldon-Stemm—I can see the logic in it, but I am afraid it is a failed logic. Suicide is something that you have to keep at all of the time; it is not something that, if it suddenly decreases, you can say, ‘We don’t have to do anything more about it.’ A similar analogy has been made to the road toll. If we said, ‘The road toll has decreased dramatically so we’ll open the speed limits, we’ll take the police off the roads and so on,’ what would happen? The road toll will go back up again, and that is exactly the same for suicide.

The other thing which is not covered in suicide is suicide and self-harm. The two have to go together because just looking at suicide statistics does not tell you the rate of self-harm. And quite obviously there has been an increase in services and a benefit in that area, which means you are capturing more people probably beforehand. In our case, where we have three to 500 interventions a year, those people, if we had not intervened, would have ended up either in hospital or completing suicide. That is not measured at all; there are no statistics covering that area. So what you are doing is looking at an endpoint without in fact looking back through the funnel at the rest of what is happening, and it is a very closeted view and, for us, it is an incorrect view.

Senator ADAMS—Coming to self-harm, as far as people who have self-harmed and have had to take themselves to emergency departments, in Hobart, do your emergency areas have a special mental health person associated?

Mr Sheldon-Stemm—I do not know.

Senator ADAMS—You do not know?

Mr Sheldon-Stemm—No. The issue with our program is we are not in the mental health paradigm; we do not operate from a mental health perspective. It is not connected to mental health. We deal with people on a day-to-day basis in their communities, at their homes, amongst themselves. The phrase ‘mental health’ is never mentioned in any of our programs, we do not talk about it. We talk about emotional health: how are you feeling emotionally today? Connected? Disconnected? Good? Bad? Whatever. We have deliberately taken that because we see that is where the greatest gains can be made in assisting people who have suicidal thoughts, or who might be at risk of suicide. That is the place you need to go first because the mental health part is all at the back-end of it.

Senator ADAMS—These people who have self-harmed that you are helping and who may have had to go—

Mr Sheldon-Stemm—No, with most of them we help; we intervene before they self-harm.

Senator ADAMS—I am just trying to get some statistics because other evidence we have had is the fact that if they do present to an emergency department, there has not been anyone there who can help them psychologically. They have been pushed to the back of the queue and there have been some rather horrific issues mentioned about the way they have been treated, so I was really trying to get to that to see if Royal Hobart and your other large emergency areas did have somebody available to talk to these people.

Mr Sheldon-Stemm—Perhaps I should explain what we do. Our program is based around the fact the person will give off signals and signs. We teach the community skills to read signs of someone who may be at risk—signs like giving things away, signs of being well-dressed and then suddenly being very sloppily dressed, signs of being on time and then all of a sudden late. We skill the community to look at their family, friends, workmates and so on and to basically talk to them about it. We have an intervention method which is very simple, very easy, and once they have identified the person is at risk, they will then mentor them to help. So they do not just simply say, ‘We’ll ring the emergency department, we’ll get an ambulance to come and take you.’ This is what our program is about: ‘these are friends, families or workmates of yours; you need to care for them in this short period to refer them on to the services most appropriate to them, whether that be the local GP, the emergency department or a local counsellor. Whoever it might be, they assist the person to access those services. That is what our role is—beginning and end: identify, intervene and transfer on. That is where we may catch the person at the very earliest stage that they are at risk because we are able to identify the signs that they show. So asking me about the back end, after they arrive at the hospital, we do not have any evidence or any involvement in that. Our program is very much at the farm gate, if you would like to call it that. That is what we do, and what we have done very successfully for seven years.

Senator MOORE—What makes your system so different? We have a list somewhere, which I cannot lay my hands on at the moment, of all the money that the government spends on suicide programs in the country. The bottom line of your submission is that you cannot go on doing the work you do without funding. You have been unsuccessful in getting further funding from the federal government, and so far you have not been able to break into any of the state governments.

Mr Sheldon-Stemm—That is right.

Senator MOORE—We will speak to other people about this, but we have pages of programs that the Commonwealth government spends money on in suicide prevention. When you spoke to the minister’s office, when you have spoken to other people, what makes your program different and what is the problem with getting funding?

Mr Sheldon-Stemm—There are two things, or maybe three.

Senator MOORE—And maybe four.

CHAIR—You can do as many as you like!

Mr Sheldon-Stemm—The first one is that when we talked to them about what we do, and we got this from the department quite a lot, we were initially told that we should not be doing what we are doing as teaching ordinary people to intervene in this process was very much the domain of health professionals. So you need to be a psychologist or a counsellor or somebody of that ilk to intervene. We have proven them dramatically wrong. However, they are still of that view. They are still of the view that a program which is about ordinary people caring for ordinary people is outside the paradigm that they will work in.

The second thing is we do not want the funding for the programs; we want somebody to give the community the funding because this is about community ownership. What happens is the community purchases the funding, the program from us and they have ownership of it. Of the five programs that were completed in Tasmania, I would have to say results in all five areas—one has been quite spectacular, but the other four have been very mediocre because there was a lack of ownership by the community. One of them, West Tamar, they were looking for money for some time to get their program going, so they were well and truly geared up and ready to go. The others were saying, ‘Good, we’ve got money from the government.’ That is not how we work, that is not how it works. And when I have made mention to the minister’s adviser that perhaps she should be giving money to the community rather than to us, she said, ‘That’ll never happen.’

Senator MOORE—The system is not developed for that process.

Mr Sheldon-Stemm—No.

Senator MOORE—What about local government?

Mr Sheldon-Stemm—Local government have been extremely supportive. In all the areas that we operate in we have connected to the local government, but, of course, they do not have any funds to do this sort of thing. The third thing is to do with the fact that we are not an ongoing service. We only have to go to a community once. The program costs $35,000 for a community for one year and after that we require no further funding for that community to continue to operate. We now have communities that have been operating for seven, five, four and three years without any funding and yet the program is still running in the community. The department cannot get over the fact that it runs this way. They say, ‘No, you need more money next year.’ We say, ‘We don’t want recurrent funding for that community; we need funding for a new community.’ They say, ‘No, we are happy to give you recurrent funding.’ The system is such that once you get a bucket of money they happily keep giving it to you for that same community. We want to transfer it to another community, but the system does not work like that. In each case we seem to be working outside of the system as such. They are the main reasons. Of the 22 programs, six have been funded by the Commonwealth and the other 16 by local communities, philanthropists or people who have a real sense of community.

Senator MOORE—You are very clear in your submission that the role is not psychological or professional—that the ABC process automatically means that, if people are discovering that there may be issues with someone, their role is to be supportive and to refer to other professional bodies as required. It is not like you are taking over the work of other agencies; it is a referral basis.

Mr Sheldon-Stemm—That is right, but most people do not get that.

Senator MOORE—What is your relationship with organisations such as Lifeline that have a system in place?

Mr Sheldon-Stemm—It is really interesting when you go to a community and you have your first training. We say to the people in the community when we focus on community attitudes, ‘What are the resources in your local community?’ For the first five or 10 minutes people will say, ‘We don’t have any.’ Then we start listing them and invariably get a whiteboard full of services like Lifeline, the local GP, the council down the road—

Senator MOORE—Churches.

Mr Sheldon-Stemm—There are heaps of them. If someone in a rural-remote area was assessed as being high risk and the local doctor was miles away and so on, Lifeline is definitely one of the resources—‘Let’s get you to talk to someone at Lifeline.’

Senator MOORE—So there is no competition as such; it is not a competitive model?

Mr Sheldon-Stemm—No, there is no competition there. We rely on Kids Helpline in Melbourne and Men’s Helpline—those types of services are listed as resources for our service.

Senator MOORE—So the focus there is the community taking ownership. How many communities did you say you had queued up wanting to use you but do not have the money yet?

Mr Sheldon-Stemm—About 24 or 25.

Senator MOORE—The ready-made business is there if there were funding?

Mr Sheldon-Stemm—Yes.

Senator MOORE—My other question is about how you keep people on track. I know that you do the initial training and go away and you can be helping out for that 12 months. When you have people trained and they are passionate, how do you keep them from over-identifying?

Mr Sheldon-Stemm—There are two ways. First of all, each community forms a community group, normally of between 20 and 50 people—so we set up a formal structure within the community. They connect with each other and meet on a regular basis. We provide outside training to them and separate skills. We do separate skilling during the program, such as grief and a lot of other training. That core team basically self-manages. You are likely to get at least one or two people who are very—

CHAIR—Gung-ho?

Mr Sheldon-Stemm—Yes—zealous, while the others tend to temper that. If you get a group of 20 or 50 people together, you normally have that good mix of some who are at one end and others at the other end. That is important to the program, too. Until you form that core group that basically works together, the program does not work. That is where it starts. They do a really good job. We have been doing it for seven years and that has worked really well. There are people who we will not give team leader training to. We assess people. Team leader training consists of a four-day course and then they can deliver it to their own community. We do not deliver the program to their community. We teach them and they then do the one-day course for their community.

Senator MOORE—The way that reads is very positive.

Mr Sheldon-Stemm—There are several people who put themselves forward and say, ‘I want to be a team leader.’ We do a fairly rigorous assessment. Whilst we are not seen to be on the professional side, our processes are extremely professional. We have a continuous improvement system. We have comments from all of the 1,800 people who have done the course, in terms of: ‘What was the course like; what did you get out of it; what did you think about it?’—all those types of things.

CHAIR—Is that the team leader course?

Mr Sheldon-Stemm—The one-day course.

CHAIR—I just wanted to clarify.

Mr Sheldon-Stemm—There are about 70 team leaders around Australia in those communities.

Senator MOORE—You have licensed your product, so someone who is a team leader cannot use it without your—

Mr Sheldon-Stemm—That is right.

Senator MOORE—That is understandable. I wanted to get it on the record. Regarding the linkages in the community, one of the things we have been trying to find out is how you build community strength. You are saying that your program has tapped into the development of community strength and resilience.

Mr Sheldon-Stemm—That is right. One of the places we often start within a community is the local community association: Lions clubs and Rotary clubs. They are the places where a sense of community invariably lies. They are the first ones that we tap into to see whether there is an interest and whether we have some ‘champions’, as we call them. As long as we have champions in those areas—someone who is prepared to do the work and put in the effort—we make an assessment whether the program will go ahead.

Senator MOORE—You made comments about the politics of suicide. I think it is really important to explore them. It is an issue that is obviously concerning you. You have raised it in your submission and in your evidence. You have a couple of key politicians who are supporting your work. You believe that, because they are not in the government ranks—you have not named them, but it is clear that they are not in the government ranks—that could be a disincentive to get funding.

Mr Sheldon-Stemm—We have been told that it is a disincentive. I have letters from—

Senator MOORE—By whom?

Mr Sheldon-Stemm—By the ministers involved in each of the—

Senator MOORE—The ministers have said, ‘Because “blah” has supported you so much—

Mr Sheldon-Stemm—No, they refer back to the department and the department says, ‘No, we have such-and-such a program running there.’ It is just one of the things we suffer from. As soon as we mention the CORES program, they say, ‘So-and-so has a program like that.’ That is a continual battle we have.

Senator MOORE—I have said the same thing, so what do you mean?

Mr Sheldon-Stemm—It is not. There is no other program on suicide prevention that does what we do. There are others who offer the one-day course, but then they leave the community. So they leave the community totally unresourced and unable to look after itself. We all go to courses and sometimes, two or three months afterwards, we think, ‘Yes, that was a really good course. What was it about?’ It is not embedded in the community. We are the only ones who embed it in the community as such. Others will do training, give talks and so on. We have an expression that we use in a country town, a village or whatever: ‘What do you do when you pack up the chairs in the hall and leave? Who is there to support the families and friends?’ There is nobody. They come, talk and say, ‘Yes, it is a really interesting topic and you have given us some skills, but who do I ring or talk to or connect with when I need to use them?’ Other programs do not have that. I do not quite understand why they do not. We started our program in the local community because we saw that there was the need for that connectedness, which was not there and, seven years later, it is still not there amongst other programs.

The first time we applied for funding from the Commonwealth, we got a letter back from the director, Sue Hunt, in Canberra which said, ‘Your funding has been denied because your program is just the same as any other.’ I wrote a very courteous letter back and asked her what planet she was on. I went to see her and when she actually saw what the program was about they said, ‘Yes, we will fund.’ This is the whole point, that the politics of suicide is that people have these archetypes in their heads as to how things work and ‘You are just the same as other people’. No, that is why we talk about emotional health and not mental health. The more you start talking about mental health in a community in terms of suicide you are wasting your time. People say, ‘I don’t have a mental health problem,’ because mental health is associated with a whole lot of stigma and other things. When you start talking about people’s emotional health then they can actually say, ‘Yes, I feel bad today.’ ‘No, I feel good.’ ‘No, I feel bad because such and such has happened.’ That is where the conversation in terms of reducing rates of suicide should be starting. Yes, we might have to access mental health services, but if you are going to start in the community using the term ‘mental health’, forget it. Our experience is that people just turn off—‘There is nothing wrong with me, I am just feeling bad because I lost my job, I lost my property, I lost my wife, I lost my kids,’ anything like that. People talk like that. ‘Oh, I don’t have a mental illness, I just feel bad and I’ve got very good reasons for feeling bad.’

Talking about addressing community attitudes, that is where you need to basically engage the community and start a program of community engagement to talk about suicide. We hear that if you talk about suicide it normalises it and all this sort of thing but, to be honest with you, we found it to be a complete myth. The more we talk about suicide in a local community actually things improve. People start to come out and say, ‘Yes, I understand.’ People who are suicidal and have those thoughts and so on, just by mentioning the word to them they are not in that place. They are not simply going to go off and do it. It is a nonsense. So we should be open about it, we should be talking to people about what suicide is about and how it has affected people, and it has affected nearly everybody. I use an analogy in terms of first aid. I have done physical first aid and in 15 years I have used that skill once. In seven years of this skill I have used it six times. I am likely to use this first aid skill six times as much as physical. Look at the amount of money you spend on training people for physical first aid, and yet there is no training for this first aid, no training in emotional health, no training in how people should care for each other or how they should be connected or how they should ask the questions—nothing. We do not understand why we are like that. Why do we shy away from it, why don’t we go there?

Senator MOORE—One of the things that has been funded by the national body is an organisation in Melbourne that is a place where all of the services around Australia dealing with suicide are listed. I forget its name—Crisis. You are not included in that register?

Mr Sheldon-Stemm—No, we are not listed on the DoHA website, we are not listed anywhere, because we are not seen as being part of the system as such. We do not mention mental health, we do not talk about mental health. We are not a member of SPA, we are not a member of the mental health councils or anything.

Senator MOORE—Did you win an SPA award?

Mr Sheldon-Stemm—We did indeed.

Senator MOORE—You won the award but you are not mentioned—

Mr Sheldon-Stemm—That award I think was nominated by John Dawkins here in South Australia. He is the upper house rep. We also won a Tasmanian award.

Senator MOORE—So you have been acknowledged by the national NGO but you are not listed with the NGO as a service. We will follow up.

Senator WORTLEY—Thank you for your submission. This is probably a continuation of the questioning from Senator Moore. Could you clarify the specific difference between what you deliver to a community and what other service providers who are registered or listed provide? How do you differ?

Mr Sheldon-Stemm—We differ in the fact that our role is to basically build community capacity and social inclusion, and from there give them the skills to deal with suicide.

Senator WORTLEY—So another organisation that would go in, hold the forums, provide skills training to a number of members in the community at a particular forum. Let us get to that point. You going into the training, you have one-day training; is that right?

Mr Sheldon-Stemm—We have an initial one-day course, yes.

Senator WORTLEY—How many people in the community would attend that?

Mr Sheldon-Stemm—Normally, this year, about 20 or 30.

Senator WORTLEY—So you have 20 to 30 people attend the course; what happens next? I went through your submission but I am just trying to differentiate between your organisation and other organisations.

Mr Sheldon-Stemm—Initially we get somebody who contacts us and says, ‘We’re really interested in your course.’ In fact, we are about to start a program in a community in Victoria. They contacted us. In fact, Coralanne, our manager, is there at the moment actually doing a one-day course. Those 20 or 30 people who do the one-day course then decide whether they want a CORES program. They then come to us and say, ‘Yes we do, and we have formed this team.’ So they form a team. We then say to them, ‘All right; now you have formed the team, you need to decide who, amongst you, you wish to have as team leaders who will be able to train the trainer.’ So they decide who they are and put them forward to us. We screen them, quite obviously, to make sure they are appropriate. It is normally between four and six people. So we then go back and train those four or six people.

Senator WORTLEY—So you go back into the community and train them.

Mr Sheldon-Stemm—We go back into the community and we train the four to six team leaders. They then start running the one-day courses in the community and that normally takes two or three months. Over the next nine months, each time they do the one-day course as a team leader we go to the course with them and we mentor them through that.

Senator WORTLEY—And how many one-day courses would the team leaders provide that you attend?

Mr Sheldon-Stemm—Normally about 10, a dozen or 15 in a year. The thing with rural communities is: there is a fairly small degree of separation, which means that people know each other pretty well. They are connected. So you do not need to teach everybody—you only need to teach normally 100 to 200 people in a community. That is enough of a connection, because people will know that they have done the course.

Senator WORTLEY—And when they hold these courses, would it be at educational institutions?

Mr Sheldon-Stemm—No, it would be at the local town hall, for example.

Senator WORTLEY—What about the people in the community who would be attending these courses? Would they be just anybody in the community who wanted to attend?

Mr Sheldon-Stemm—Anybody. We have had professionals such as schoolteachers and policemen and so on, but also housewives and labourers—people who have a genuine interest in actually doing something.

Senator WORTLEY—So you hold these courses and you attend with them. And then what happens?

Mr Sheldon-Stemm—At the end of the 12 months we let them run and they continue to train. They will hold normally four or five courses during the year. We will supply them with materials. We will visit them during the next 12 months to see how they are going and what they are up to. We get all their team meeting minutes. They meet either monthly or bi-monthly and all those minutes come back to us. So we monitor them to see how they are going and what is happening. That is where we actually capture the interventions, because at each of the team meetings people report any interventions that have occurred in the community. So we capture that data and we are able to monitor from a distance to see how the community is going.

Senator WORTLEY—And this is the cost to any rural community—$35,000? Is that right?

Mr Sheldon-Stemm—Yes, that is it: $35,000. And then, after that, they will charge $50 per person in the years afterwards just to pay for the material and the morning tea. It is also based on volunteers—all these people in these communities are volunteering. None of them are paid, because our whole emphasis is on the fact that you are giving to your community through this volunteer process.

Senator WORTLEY—So the $50 per person—what is that for?

Mr Sheldon-Stemm—After the initial $35,000 one year, if you then come to a course they charge you $50.

Senator WORTLEY—As a team leader, if you come to a course?

Mr Sheldon-Stemm—No—if a team leader were to hold the courses in their communities. Just say they get 10 local people who want to do the course, they charge $50 per person for that.

Senator WORTLEY—And where does that go?

Mr Sheldon-Stemm—That goes to the local community. And often what happens is that they raise money—sometimes a team leader might leave. That happens in communities. People leave. So they want another team leader trained. It is $1,500 to train the team leaders. So, having run their one-day courses, they will collect their money or they will do fund raising—they will do cooking; they will do a whole lot of different things—with which they will pay for the person to come to Tassie to do the team leading.

Senator WORTLEY—So they have the $35,000 initially and then, if they need additional team leaders down the track, it is $1,500 per team leader?

Mr Sheldon-Stemm—They raise the money, yes. That is right. But they find their own money for that. And that is part of their ownership; that is part of belonging and having the program belong to them.

Senator WORTLEY—I have one last question, in relation to Tasmania. You have been in Tasmania for how many years?

Mr Sheldon-Stemm—Seven years.

Senator WORTLEY—And what has happened to the suicide rate in Tasmania during that time?

Mr Sheldon-Stemm—All I can say is that, in the communities where we have had the program introduced, the suicide rate has dropped dramatically. I know that, in Kentish, before we introduced the program we averaged two or three a year, whereas, on the national average, we should be on about two over three years. But since the program was introduced in 2003 I think we have had two deaths in seven years.

Senator WORTLEY—One final question. In rural communities are we seeing suicides or attempted suicides in the older age group or the younger age group? Is it consistent?

Mr Sheldon-Stemm—It is across the board—men between the ages of 24 and 49 are still at risk, but older men as well.

CHAIR—Thank you very much. We have run out of time. As you could see people were deeply interested in your program. I appreciate your travelling to come and talk to us. It is very much appreciated.

Mr Sheldon-Stemm—Thanks for the opportunity.

[11.31 am]

HARRISON, Associate Professor James Edward, Private capacity

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

Prof. Harrison—Yes.

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

Prof. Harrison—Really all I want to do, in the form of an opening statement, is to speak briefly to the outline of my submission and make a few remarks concerning new information that has become available in the few months since that submission was made. I should emphasise that I am restricting my remarks—and my submission was restricted—to the second of the terms of reference. I am solely talking about information on the occurrence of suicide in Australia and ways in which the information that is currently available is imperfect and ways in which it could be improved.

There were four themes that I spoke about in my submission. The first is what I call ‘primary capture’. That is the issue of where information about a death is first received by official processes and is entered into records of one sort of another. In the case of sudden and unexpected deaths, as suicides generally are, that first contact is most usually with police officers who attend scenes of deaths and, amongst other things, report the facts of deaths in their initial assessments to coroners.

The second theme of my written submission is related to the complex nature of the system or the processes that sit between the primary capture of information about a death which might ultimately be recognised as suicide and the production of the statistics generally published by the Australian Bureau of Statistics, which are the common currency of discussions about suicide in Australia. So I point out in the submission and in some other publications of mine that there is a moderately complicated process that sits between those two events that involves, as I have already mentioned, police; coroners; in coroners’ offices, coroners’ officers; forensic pathologists and the coroners themselves.

For roughly the last decade it has also involved a process that has been developed by, and with the blessing of, coroners around the country—an institution known as the National Coroners Information System, an electronic on-line system that is designed to enable better, more reliable and simpler recording and access to information on the deaths that come to attention of coroners. There are also processes involving the Australian Bureau of Statistics and its publications process.

The second theme of my submission is that I think this moderately complicated process could be better coordinated. During the first decade of this century there was a period during which there was interaction of some steps in that process, which has led to a non-trivial, artifactual reduction in the suicide counts published by the Australian Bureau of Statistics—in other words, due to a lack of coordination of a timing of processes involving those different components. The net effect was that the statistics that were published by the ABS under the heading of either suicide or self-inflicted harm were lower than they would have been had there been a different kind of arrangement between those organisations.

I would point out that there is no, if you like, single institution in Australia that has overall responsibility for the production of cause of death statistics. It is a process that has evolved over a century and a half and involves state level agencies and a Commonwealth agency in the Bureau of Statistics. It relies very heavily on informal agreements, on trust and on the operational goodwill of the various components of that process which, I should say, has generally been good. Australia is known to have generally good cause of death statistics in world terms but a system like that is vulnerable to perturbations. In this case, the one that I am talking about was an unintended consequence of a good development and it is one which some more recent process changes which have been introduced, chiefly by the Australian Bureau of Statistics, will ultimately overcome, but there is a long wash-through period for that correction process. We are not yet there. I would be happy to talk in more detail about that, if you wish.

But, in rough terms, I think it will be several years before we begin to have, if you like, a new platform, a new time series of post this problem of cause of death statistics out of the Australian Bureau of Statistics system that is long enough for us to be able to provide reliable and straightforward assessments of trend in suicide according to that measure. The main problematic consequence of this, in my view, is that it has interfered with our ability to provide reliable assessments of trend, of change in suicide during the past decade and that relying solely on that system will continue to be problematic for a few more years.

The third thing I talked about was the more abstract notion of the conceptual model on which one bases the statistics that one chooses to report as suicide. As I am sure you have heard from witnesses or read in written submissions from others, suicide and related phenomena and intentional self-harm and so on are, in some senses, quite straightforward and obvious but are also a conceptual abstraction. There are not terribly sharp boundaries either conceptually or, when one comes to look at individual cases, between deaths which absolutely, clearly and indisputably meet some conventional definition of suicide, such as intentional self-annihilation or self-murder and deaths which clearly have nothing whatsoever to do with that concept. In between there are various shades of grey and various degrees of uncertainty. The uncertainties may exist solely in terms of the information available to us, to investigators, to coroners and so on. That may occur, for example, in the instance of a death by drowning where a person vanishes. They may have left some evidence; they will have had a past history, which may or may not include certain factors such as a past history of depression or of previous suicide attempts. But, in a situation such as that, the coroner and other investigators may really be confronted with a lot of uncertainty about what led to the death on that occasion.

Similarly, there are some circumstances of car crashes and a number of other situations like that that are well known to investigators and coroners in the area as being quite often problematic when it comes to assessing the circumstances, although perhaps the person involved may have had a clear intention. But there are also issues of unclear intention and of malleable mood and of mood and state of mind being affected, perhaps temporarily, by alcohol and other drugs and so on, and circumstances in which behaviours might be seen as suicidal or as extreme risk taking, perhaps to the extent of representing reckless indifference about consequences, for a variety of reasons. So there is a set of these circumstances that do mean that, even with very good information about a case, it can nevertheless be a rather difficult and perhaps infeasible issue to simply and reliably and unambiguously assign this death as suicide—clearly nothing but—and some other death as not suicide. There are these inherent difficulties around the measurement of a phenomenon such as suicide.

I do not want to overstate that. For a large number of deaths, including all or nearly all of those that I think are currently reported as suicide through systems such as the Australian Bureau of Statistics, there is little doubt that those cases can properly be regarded as suicide. I think the issue is more one of there being a grey zone beyond that, a penumbra of cases that, for some purposes—I would particularly say for public health purposes and assessing size of problem and so on—can usefully be seen as at least being suicide-like and perhaps usefully seen that way in the context of targeting programs and so on, but which may equally be appropriately not called suicide by a coroner. But, at the moment, this group is essentially invisible to us statistically.

I am not sure whether you have spoken to Professor Diego De Leo, but I know that he has been advocating some kind of counting system in which there are a few gradations of certainty that can be recorded in some way. I think there is something to be said for approaches along those lines, although they need careful assessment before being introduced on a routine basis—conceptual models.

A second thing about conceptual models that I would like to point out is this. Fortunately, suicide, while much too common, remains a relatively uncommon event, even among people who might be judged to be at high risk of suicide—somebody with a past history of depression and so on. However, there are many other behaviours that such people may undertake that do not, at least immediately, have a fatal outcome—intentional self-harm that might lead to attendance at an emergency department, or might not. In addition to that there is the widespread occurrence of suicidal ideation of one form or another—ruminations about suicide, perhaps with formal plans or not. The point of saying that is that, from a public health and statistical point of view, thinking about the phenomena in populations that are related or likely to be related to suicide, there are some potentially countable, measurable things that go well beyond the suicide cases per se.

Even if one’s primary interest is in suicide statistics and trends in suicide statistics, it is nevertheless quite important to understand something about non-fatal cases as well as fatal cases. I will mention one reason I am happy to discuss now, and I am happy to discuss some others later. If goes as follows: let’s imagine that one had very good, reliable suicide statistics and, tracking them over a period of time, one saw a rise or fall in that rate of suicide statistics. Can one, on the basis of that, assume that the level of suicidality in the population—the number of people who feel, ‘I must kill myself’—has changed similarly? Maybe that is true, but maybe not. Another potential explanation is that if in the population the type of method that people choose to use when confronted with that sense of wishing to self-annihilate changes from one that has, for example, relatively low probability of leading to death when that method is used—for example, most forms of overdose—to one that has a very high probability of death when it is used, such as hanging, in most circumstances, and use of firearms, one could get a rise in the number of suicides with no change in the number of people who are attempting suicide. Conversely, if there were a shift from a more to a less lethal means, it could have the converse effect. So, even with very good statistics on the occurrence of suicide deaths, there is still some uncertainty about what is going on in terms of the background of suicidality.

This is not just a theoretical phenomenon. In Australia you may be aware that there was a dramatic epidemic of suicide in the 1960s, chiefly suicide related to barbiturate poisoning, and this corresponds very much with the arrival onto the Australian market, and subsidised by the then new Pharmaceutical Benefits Scheme, of barbiturates as the predominant sleeping medicine at the time. Barbiturates are a much more lethal medicine than the types of sleeping medicines that were common in the decade before the 1960s or the types of sleeping medicines that were common in the decade after the 1960s. It is a little difficult to prove absolutely, but I think that much of the explanation for that big epidemic—which tripled the female suicide rate over a period of a few years—was related to a change in the lethality of the pill that people found in their hand when they reached for the sleeping pill bottle that was in the bathroom cabinet or beside the bed.

I think we have in Australia a fairly marked example of where suicide rates can change without necessarily implying a change in the underlying suicidality but perhaps reflecting a change in what people do or the lethality of the means that people use. How could this be important in Australia? For example, if young women were to increase further their use of hanging, asphyxiation, as an attempted means of suicide over overdoses of pharmaceuticals, it would be conceivable to have a similar effect. If one is interested in trying to understand this sort of phenomenon in a population, one has to look beyond just measuring the deaths to measuring these other phenomena in populations. I am, again, happy to talk later about ways in which that can be done and some conceptual models for it.

What I will say now is that, while that has been very difficult in the past, there are some developments in health statistics generally in Australia that are coming online now and that are in place and well established in two states—Western Australia and New South Wales—and are being developed in other states, including South Australia and the Northern Territory, that are making it much more feasible to build information systems that would have these capabilities. I am talking about administrative data linkage systems. These are systems that can join up multiple sources of information, including deaths data, hospital admissions data, hospital emergency departments data, potentially mental health service data and a variety of other sources of data, in ways that make it more possible to measure things in relatively sophisticated ways in populations.

The fourth and final thing that I make a point of in my written submission is a question of resources. In big terms, a mortality data information system is not a very expensive operation. But I would point out that the two key points on which Australia’s deaths information system rely are both, in my view, relatively poorly resourced. Those are coroners offices. Within the pecking order of the judicial system, my impression is that coroners offices in general rank relatively low, and I think that is evidenced by the difficulty in obtaining good, strong resources within their offices to enable good, rapid recording of the information on which the NCIS, the National Coroners Information System, relies and therefore on which the ABS deaths data system relies. Secondly, within the Bureau of Statistics itself, a big agency and one that has had to manage cutbacks and has ceased certain collections and so on, I think it is only fair to say that through my experience the small group that is responsible for the production of the cause of death statistics and births and marriages statistics is very small and has become smaller over recent years. I think that, while they are doing good work and working very well, the resourcing issue should not be overlooked. I will stop there.

Senator ADAMS—That was very interesting information. There was so much of it. You have probably heard me ask this question before. There are statistics in some research that was done on New Zealand and also an assessment of what it would cost per individual for suicide in Australia. Have you done anything on the costings?

Prof. Harrison—The cost of a suicide happening?

Senator ADAMS—Yes—the cost of suicide to the Australian people.

Prof. Harrison—The short answer is no.

Senator ADAMS—The figures quoted show that it could cost up to $2 million per suicide.

Prof. Harrison—That sounds plausible. Unfortunately quite a large proportion of all the suicide deaths occur at relatively young ages. There are various economic models for costing an untimely death. A small number of millions of dollars is the sort of value that one quite often sees in context, such as in costings of road deaths or work related fatalities and so on. It would have a similar age distribution, so that does not surprise me.

Senator ADAMS—As far as community sensitivity is concerned, how do we get the message out to the general public? You probably heard the evidence earlier. It is something that you push away and it goes away and we do not talk about it. The road toll certainly is advertised very widely: ‘Do not do this and do not do that,’ and all the rest of it. How can we get a breakthrough? Do you have any idea through the research you have done how we can get a breakthrough to advise the public of just how serious this is? With the data that you have used, we have a lot of constraints as to why we cannot really come up with the absolutely correct number of suicides that take place.

Prof. Harrison—As an aside, the example you raised of the road toll is a good one. It is perhaps something I should have remarked on myself. Regarding the timeliness and availability of pretty reliable statistics on road deaths, such information has been available for decades. There are the underlying social processes of police attending the scenes of those deaths, and police being the primary data-capture process for road deaths is pretty much the same as the one I described for suicide. I can see no reason in principle why we should not have similar fairly complete and fairly reliable data on suicides very quickly. That is a quite feasible thing to do if we want to do it. Indeed, in some other cases—Ireland is a case in point—police report directly and under terms of confidentiality to the national statistics agency very quickly. That is the primary basis of quite quick and reasonably reliable statistics.

What should one do with such information if one has it in hand? I am not at all convinced about running a program similar to the way the number of road deaths is used on an everyday basis—that is, the number of road deaths yesterday, and so on. I find that very unappealing in the context of suicide and it could well do more harm than good. Nevertheless, making somewhat different use of that information is a good idea. Again, this is heading a little bit out of my area of expertise. My focus is on the measurement issues rather than, primarily, the use of that information. But I certainly think that it is quite possible that a wide range of information could be obtained and provided quite rapidly to those whose business is in the public communication of such information. We could do a lot better than we do now. It seems to me to be quite unnecessary that we should still, in the 21st century, need to wait for years before we can obtain even incomplete information on the population level in the occurrence of suicide. It could be that there are good, strong and defensible reasons for using current information as part of the public process on this. Often recent information is more potent than old information when one is communicating with many sorts of people—public officers, politicians, community organisations—and perhaps, for only that reason, there are some good, strong reasons for taking the efforts to ensure that the information we have available is much more current than we are able to provide now: quarter by quarter or six months by six months. Sorry—I have diverged a little bit from what you are asking.

Senator ADAMS—As far as funding sources go, of course, you have got to have the evidence to back up why the relevant governments would put funding into something. If you have not got the right base at the start, you are just not going to be able to attract that funding to do further research. This is really what concerns me about the figures, because if we cannot get the right figures then we are never going to get the adequate funding that we need to try to help with the prevention programs. We have had a lot of examples of how people deal with these.

I would like to go to Indigenous communities. Have you done any work on statistics in that respect as to cultural non-English-speaking background and Indigenous areas?

Prof. Harrison—Yes, I have done a moderate amount of work concerning fatality and injury hospitalisation statistics generally for Indigenous Australians. Part of that has related to suicide statistics but not solely to that. There has been what has become a well-known problem concerning statistics on health outcomes and mortality for Aboriginal people of all causes, namely that, to various extents in the different jurisdictions, the identification of Indigenous status has been incomplete. So in general in Australia I think you could say that nearly all deaths that occur come to the attention of the official processes and the statistical process, so we do not think there is a large number of deaths that are completely hidden. But in terms of Indigenous status there are quite a lot of deaths that if you knew more about the circumstances of that individual or the way they perceive themselves you would say, ‘Yes, that person in life regarded themselves as Indigenous,’ but in public statistical systems that person is not recorded as Indigenous. There are various reasons for that and, as I said before, the extent of that differs between jurisdictions, being least generally by most estimates in the Northern Territory and most in the states of the south-east.

This issue has been the subject of a lot of attention and efforts to resolve it over particularly the last decade or 15 years. There have been some improvements in that regard but there is still some distance to go. To some extent the efforts to date could be summarised as being try harder to get the correct information and do so in a more systematic manner. A decade or so ago there has been introduced a standard question that now appears on both of the two forms that have to be completed in the course of the information processing following a death. One form is the medical certificate death which is completed by a medical practitioner for most deaths but in the case of most suicide deaths is completed for and on behalf of a coroner. The second form is the so-called form of information on a death, which is generally completed by or via the funeral director in consultation with a family member who the funeral director believes to know about the circumstances of the deceased person. Both of those forms have this standard question block on them now which asks a standard set of questions: was the person Aboriginal, was the person a Torres Strait Islander, was the person both, was the person neither? Effectively that is what it asks. When I said before that much of the effort in recent years has been a try harder approach, I mean by that that there have been efforts to encourage doctors and encourage funeral directors to ask that question more assiduously, more systematically, to do so more thoroughly.

I am sure there has been an effect of that, but I am equally sure that it is not complete. I found myself in a position a few weeks ago of being asked by a funeral director, concerning a death in my family, with respect to the questions I know to be on that form, where the funeral director did not ask me that question. I then asked him why he had not, and how often he did ask it. This is in Victoria. He said he rarely asks it, and finds is embarrassing to ask it. He was of the view that he would be causing offence, in many circumstances, if he did ask it. So that is also what I mean when I say that I think there is still some distance to go in terms of improving the statistics.

In the latter part of my remarks I mentioned that there are some more sophisticated health information processes, based on data linkage, that are becoming available. There are some prospects that a system such as that could be used to help overcome those sorts of issues. Technically, at least, the ethics of it is very difficult. We talked about the technical process to begin with. What such a data linkage system does come up with is, if you like, a joined up set of records which, according to that system, all refer to the same individual. So that might be, for example, a birth record; it might be a series of hospital admission records; it might be a mental health record; and it might be a death record. One could, as part of the linkage process, and with the appropriate ethics clearance and the permission of the data custodian for each of the data sources from which those records came, find out whether each of those records attempted to record Indigenous status. If they did, one could then look at what was the value, for a given person, looking across what might be 10 records that belong to that person, to look at whether some or any of them record that person’s Indigenous status as being Aboriginal or a Torres Strait Islander. So one could, from a method like that, to some extent, bypass or overcome a process like that of the funeral director that I was referring to a minute ago. But that would be subject to very stringent ethics clearances, and I am not sure whether a project of that type would be judged to be ethically acceptable.

Senator ADAMS—That is very interesting. You would think that the funeral directors must have a code of conduct or something such that they really would have to ask that question, if that is part of the data that is collected.

Prof. Harrison—One would hope so. Similar problems to the one that I described have been found in the context of hospital data, for example. There have been some specific studies undertaken in that context. I am thinking particularly of some that were conducted a few years ago in New South Wales. It was found that the front-of-house staff, the triage nurses and others who record information about patients attending emergency departments, often did not ask these questions, for similar reasons to the one that the funeral director gave—feelings of embarrassment or offending people and so on. There was a common practice of judging people by appearances. There have been some efforts to train these people, encourage them and force them; and there is some evidence that that has improved, but I suspect it is still not perfect. One of the things that is pointed out by people who look closely at this is that the context affects the probability of asking the question a great deal. In the Northern Territory, it is no big deal—asking this question is regarded as very ordinary, conventional and polite. This is in a context where a large proportion of the population is Indigenous, and it is just normal in such a context. In the eastern suburbs of Melbourne, in which the event that I was talking about occurred, it would be unusual. The funeral director would probably have to ask the question a couple of hundred times before encountering somebody for whom the true answer is yes. You can understand that if, in the course of asking the question 200 times they encountered 10 people who said, ‘I’ll never use your funeral director again; I’m terribly offended’, that this could be some kind of structural disincentive to asking the question.

Senator MOORE—Professor, are you involved with SPA, the suicide prevention group?

Prof. Harrison—Loosely.

Senator MOORE—It is just that they have a subgroup of SPA that looks specifically at these issues of statistical records. That seems to align with your passion, and I was wondering whether you have had anything to do with them.

Prof. Harrison—Yes, I was at the first meeting of that. I was unable to attend the second. I am a co-author of the paper that is described in the—

Senator MOORE—We could talk for hours about different things, but I just wanted to get that on record.

Prof. Harrison—I want to make one final comment: I have talked about a lot of the difficulties in this, and I think that, at base, coming up with good enough straightforward suicide statistics quite rapidly is well within the capability of a country like Australia. The refinements, much of which I have been talking about, are good and important, but it is a reasonable expectation that we should have available rapidly information that is good enough for statistical and monitoring purposes quite quickly, as we do for road statistics.

CHAIR—As there are no further questions, I thank you very much.

[12.07 pm]

COWPER, Ms Lindsey, Assistant Principal, Student Wellbeing, Victor Harbor High School

PEARMAN, Ms Jill Kathryn, National Coordinator, MindMatters Project, Principals Australia

ZILM, Ms Tracy, National Training Coordinator, MindMatters Project, Principals Australia

CHAIR—I understand that each of you has 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. You can each make an opening statement, or one of you can and we will ask all of you questions.

Ms Pearman—We decided that we might split the opening statement, so we will try to be concise. Thank you for the opportunity to come today and to present to and speak with you. This is a very important inquiry, from our angle certainly—that is, the importance of promotion, prevention and early intervention in a school setting, which is where MindMatters sits. MindMatters started in 2000. It is funded by the Department of Health and Ageing and it is operated by Principals Australia. We feel very passionate as a team about the importance of that promotion and prevention and early intervention in the role of suicide prevention.

I suppose the thing about MindMatters is that when it started in 2000, originally there was a kit that was sent to schools. Some of you may be familiar with that. There are lots of them around Australia in every secondary school. Along with that kit of eight books there was also training, which was to bring the kit to life—looking at issues around mental health and wellbeing. Since that time, more than 130,000 people from approximately 3,500 schools and sites nationally have accessed MindMatters training and support in some way.

We know the importance of dealing with mental health problems in adolescents, particularly with the adolescent person in the stage of development they are at with a developing brain and how important the role of school is and how long they spend in a school site. MindMatters focuses very much on trying to build that relationship with the school and on allowing the young person to feel connected and to deal with issues when and if they come up. Young people are in a stage where they are looking at where they fit in, how they see the world, working out their own identity. Quite often it is the time in adolescence where they are trying to find people away from their home site who say they are okay, and quite often the school is the setting for the ‘significant other’. We know the role of significant other is absolutely critical in mental health outcomes for young people, particularly during their adolescent years.

Obviously one of MindMatters’ key goals is to reduce stigma around mental health and mental illness, and of course to promote seeking help. Our early work in MindMatters was promoting the MindMatters kit via level 1 training. After our five evaluations, we extended our training to offer a level 2 process, which is taking on board students experiencing high support needs. To do our work we partner with quite a lot of organisations nationally and in every state and territory, including health providers, other education providers. We specifically work closely in partnership with people in Reach Out, COPMI—Children of Parents with a Mental Illness—INSPIRE, Lifeline and Kidsline. They are resources that are promoted at training and we work with those organisations to promote them. In our new contract we have formalised a national partnership with Headspace, which we are very excited about. There is a lot of really nice work going on already; the formalisation of that will mean our high-support-need work will be strengthened.

Ms Zilm—MindMatters is about what we term a ‘universal approach’. I do not know if I am allowed to use props, but based on the World Health Organisation model, we are saying that what MindMatters does is for 100 per cent of students. So we work with all teachers and all students to create places where students can be mentally healthy. But it also acknowledges that there will always be some students who need some extra support, and there will be the three to 12 per cent who need clinical intervention, and we might say that kids at risk of suicide will be down at what we refer to as the pointy end.

But we see the role of schools and what we try to do in MindMatters is work across that entire spectrum and support schools to get processes in place and environments in place where perhaps fewer young people will end up at the pointy end. Or if they do find some things in their lives that are issues for them, that they will be able to move back up, requiring less support over time. So we know that identifying someone who might be at risk of suicide is difficult and we know that you can put things in place to identify kids at risk at one point, and overnight something has changed in their lives. So the movement of students up and down that continuum happens over time, and it is why we focus on the whole school and all students to try to catch and develop the skills of students in coping with life and promoting resilience and giving them a language of mental health and teaching them about positive coping strategies and help-seeking skills, and getting them to develop that before an issue might arise where they feel they have no alternative open to them.

We work with teachers to help them learn how to create those environments, those safe and supportive environments, and to teach that it is okay to seek help. They teach kids about bullying and harassment, how to deal with it, about understanding mental illness, about issues of loss and grief and normalising that and building relationships. We also talk to teachers and schools and all the staff in a school, not just teachers, about using referral processes. Teachers are wonderful observers of behaviour. Our training tries to hone that so that they start to develop their own awareness around mental health issues, and if a student is not travelling well, because they usually notice that, they see them regularly, then that teacher or that adult knows within the school who to refer to and the school has really good connections with the services in the community to get that student to the help that they need as soon as they possibly can.

Teachers are not counsellors, we are very clear about that, but sadly they are surrounded by mental health issues in their classes. They talk about this stuff all of the time—self-harm, bullying, suicidal thoughts—and whether they overhear it or a student opens up to them, it does happen. That is the reality. I will leave it there and hand over to Lindsey because Lindsey is one person from several hundred, possibly more, schools that we could have brought along to talk about what that means at the grassroots level where adults are working with young people.

CHAIR—Are you able to table that piece of paper?

Ms Zilm—Yes.

CHAIR—The question is that the document Ms Zilm was referring to be tabled.

Question agreed to.

Ms Cowper—When the three of us met this morning to work out who was going to say what, I realised that I had not talked about suicide at all in what I am about to say and that I had done that quite deliberately. Obviously—and Tracy uses this term—at the pointy end of what we do in schools, unfortunately we have to deal with students who are feeling suicidal and those who have harmed themselves. But when we look at the whole school we do not actually talk about suicide; we talk about building resilience. We use very positive language in the programs that we run in the schools. In the long term they are about suicide prevention, but they are about giving students the skills to bounce back when there is adversity in their lives. That is very much our focus in schools.

Very briefly, Victor Harbor High School—I am sure most of you know where Victor Harbor is; it is a beautiful place to live—has approximately 800 students. The school is classified as metropolitan when it comes to staffing, but we have a great deal in common with rural communities when it comes to the limited number of support agencies that we have in the area. That is important for us. I have been at the school for about 16 years. Our involvement with MindMatters goes back to about 10 years ago. I can remember listening to Tracy at a staff training and development session. That is where we were introduced to the concept of MindMatters and also to the MindMatters kits.

Most recently we have had a much more consistent and ongoing approach to MindMatters at our school. That involves a number of staff being trained at level 1 and level 2, which has enabled them to do some whole-school planning around the implementation of MindMatters. Various staff have attended various modules, including transitions, students experiencing high-support needs in mental health. Most recently and currently a bit of a priority in the school is involvement in the youth empowerment process. At Victor Harbor High School—and it has taken a while—this has developed a whole-school understanding of the connection between student mental health and success at school. That is a very important link. It has also developed an understanding amongst staff that they need to build positive relationships with students. It has helped to develop an environment where both students and parents feel able to access support available in the school around the area of mental health. We are reducing the stigma that some students and parents feel about contacting schools to get support.

MindMatters training has enabled staff from a secondary context—and I emphasise that; secondary is quite different from primary—to look at their classroom methodologies and make changes, whether they are a maths teacher, a science teacher or a humanities teacher, to ensure that students feel safe, valued, are engaged in their learning and have a sense of purpose about what they are doing at school. MindMatters resources have enabled staff to include material around such things as bullying and harassment, loss and grief, resilience, and understanding mental health and illness through what we call mentoring programs. Mentoring at the school is a very important part of the day. Twenty minutes every day is spent where mentoring teachers build relationships with a specific cohort of students and deliver MindMatters programs and other programs designed to enhance resilience. We have sent a wide range of teachers to

MindMatters training over the years, whether they are maths teachers, science teachers or PE teachers. We have a Christian pastoral support worker who has also been to MindMatters training, as well as our youth worker and our counsellors.

One of the other things about Victor Harbor High School, and this is as a result of the work that we have done with MindMatters over the years, is that we have made mental health and wellbeing a priority in our site development plan. That has led to the appointment of an assistant principal in wellbeing, and I am very lucky that is me at the moment. I have the role of having oversight of the whole-of-school approach to wellbeing and mental health. We have a purpose-built student services centre where there is no stigma attached to students and parents seeking help in the area of mental wellbeing. I will leave the details of that to questions. We have student support teams that operate from years 8 to 12. Teachers who have concerns about the mental wellbeing of students are able to refer to this group and a coordinated approach is developed to support the students they might have concerns about. As I mentioned previously, our mentoring program—which, again, is for years 8 to 12—has a focus on explicitly teaching young people various skills associated with resilience. A lot of those skills are outlined in the MindMatters kits.

Just a reference to the pointy end of managing mental health and wellbeing at the school: we are very fortunate in that we have a DOC program at the school. DOC stands for Doctor on Campus. We have a local GP who comes into the school once a fortnight and consults purely around mental health issues. We then have this beautiful, seamless referral to a psychologist who comes into the school fortnightly as well. We found that a lot of students, especially adolescents, did not feel able to go to the local GP. In a country town, it might have been the GP who delivered them—you do not know—so suddenly there they are in adolescence with specific mental health issues, not feeling able to access the doctor. So the fact that it is in the school means they can just come into student services and access that support there.

We have also been fortunate this year in that FLO and ICAN have moved down into the outer southern area. FLO is Flexible Learning Options. ICAN is Innovative Action Community Networks. What we have been able to do for a number of our very, very high-risk students—many of whom do have quite complex mental health issues—is to have this wraparound approach to them, where we have the Doctor on Campus involved, we have got them working in Flexible Learning Options and we come up with individual learning plans for them. It is almost like a tailor-made intervention for those students at risk.

I have got lots of evidence here that MindMatters is an effective tool in schools, and I will hand over to questions, but I will talk about what is probably the most powerful one for me. As I have said, I was in the school 15 years ago. When I was a student counsellor, I would frequently go to teachers and say: ‘You need to know this about student X. It’s fairly confidential information. Please keep it is as such, but it’s important for you in dealing with that student.’ Five or seven years ago, the majority of mentoring teachers would not have a clue what the issue was. I can quite confidently say now that, in by far the majority of cases when I go to mentoring teachers now, they already know, because they have actually built those relationships with those students. The student has actually seen the mentoring teacher and felt able to talk about it. So we are really making progress in those areas. There are lots of examples about that.

We also run a learner wellbeing inquiry every year and have done for the past four years. So we have got some data about the effectiveness of some of these programs in the school and the effectiveness of MindMatters, as well as a variety of other wellbeing programs. Again, I have got a lot of that in my head if we leave that till question time. That is basically it from a school perspective.

CHAIR—Thank you. Senator Wortley, do you want to start?

Senator WORTLEY—Having been a schoolteacher and having a young child, I am particularly interested in this area. Can I just ask about the impact of the internet, mobile phones and so on in relation to your program?

Ms Zilm—Dealing with bullying and harassment is one aspect of the curriculum content that we deal with with students, so those issues are discussed at school. In the original kit, there was not any mention of cyberbullying or internet safety, and the kit is currently under redevelopment. We have got some draft materials where it will be covered. It is waiting for our Headspace partners to come on board before it is launched. In the meantime, it is there so that it is discussed and coping strategies are talked about and what the school will do—so not only are students learning about it but the school is contemplating: how do we support this and deal with those issues when they arise?

The other thing that is probably worth mentioning is that we have an aspect of MindMatters called the youth empowerment process. I am a firm believer that the people who know most about the internet are young people themselves. The youth empowerment process is where students increase their mental health literacy and they learn about that from other students, other young people. We have got a very structured process where that happens. They take on action projects, and that will often be around the areas of bullying. For example, we are working with Tom Wood from Victoria about developing safe internet guidelines. It seems to us that when young people are talking to other young people about issues around bullying, then they tend to listen more. Professor Ken Rigby’s research suggests that as well—that students will listen more to their peers than they will to their parents or teachers, unfortunately, in those areas. So it is certainly on our agenda, it is on schools’ agendas and we are looking at developing ways to deal with that effectively.

Senator WORTLEY—How does your program in the school environment deal with the issue of suicide?

Ms Pearman—When the program was first started and launched in 2000, it grew out of the National Suicide Prevention Strategy. It is very much, as Tracy mentioned, a universal approach, looking at whole-school approaches, but within that context there is a very strong focus on the concept of understanding mental illness. In the original kit was a booklet called *Educating for life*, which is about suicide prevention and awareness. That is still part of the level 1 training. From our learnings and evaluation, the redeveloped kit will look at that a little bit differently. It would be integrated more across the booklets in a different way. As part of our training at level 1, *Educating for life* has always been a part. It has been very much around looking at some of the do’s and don’ts around the whole concept of suicide prevention. Importantly, it allows schools to see the importance of having plans in place. We have been running this training since 2000—

prevention plans—and have been very sensitive to the way those sorts of things are conducted across the school.

In fact, we understand the very importance of understanding mental health and mental illness as a bigger part of the whole school. Part of our journey has been around taking schools with us in understanding that it is not just around bringing something in around suicide prevention; it is about providing a whole-school approach and creating a safe, connected sense of belonging for the young person in a period of their development when they are quite vulnerable—the adolescent stage when their brains are doing all that stuff at the front, developing and doing what it is doing. Some people say it is ‘closed for construction’. I do not quite believe so. I have adolescent children at home, so maybe I could say it. At that time, when they are so vulnerable, we say it is not about bringing a program in, plonking it in the school and there you go. Our evaluation, with our MindMatters Plus initiative—which was in 17 demonstration schools throughout Australia—highlighted the fact that if you were going to do a targeted intervention you really needed to have young people coming back into an environment where they were supported in a whole-school way. It is about a sense of connection and belonging, and an understanding by staff and teachers about what mental health is. Some teachers would be of the view: ‘It has nothing to do with me. I teach maths. That’s something for the school counsellor to look after.’

Ms Zilm—Just thinking back to our level 1 training, where we talk about suicide, we do not make it a focus of the program, but we definitely deal with specifics. For example, a student will come to a teacher—and this has happened—saying, ‘I want to do my directed study on the issue of suicide.’ How do you handle that safely as a teacher when students are interested, without saying, ‘Oh no, we mustn’t talk about it.’ That is an example of an issue. Another is that you are studying *Romeo and Juliet* or *Looking for Alibrandi*. In some English texts there are suicides. How do you deal with that in a safe way? It even goes to the point where, if you are having a discussion in class—maybe something has happened in the community—out of the blue a teacher is faced with the conversation turning around to talk about suicide and the kids’ interest is peaked or they really want to share stories. How do you operate as someone who is not a health professional? What do you do with that? How do you deal with that? Teachers want to hear that sort of supportive information—that there are even some words that you might say—because it is such an important issue.

Senator WORTLEY—It is interesting that you use the phrase ‘deal with it in a safe way’, because what we have heard from a number of witnesses here today is that the issue of suicide needs to be brought out into the open and it needs to be spoken about and not be something that people back away from talking about. What is your view about that in schools?

Ms Zilm—About a safe way to deal with it?

Senator WORTLEY—Yes, a safe way. Does that mean that talking about suicide can be unsafe?

Ms Zilm—It is about the way that you talk about it. We talk to people about not sensationalising and not talking about the methods but making the issue part of the conversation—showing that it is okay to talk about it. If you are going to have a discussion, as a teacher you do not say, ‘This is unsafe’; you say to the kids: ‘This is obviously really important.

Let’s get a professional in to just be here as we talk about it.’ You let the counsellor know it has come up in the session in case there is a student in that class about whom alarm bells are ringing. There is all of that stuff around it. That is what we mean when we are talking about dealing with it in a safe way.

Ms Cowper—I would have to agree with Tracy. In a school context, it is very much about not getting hysterical about it. Fortunately, we have not been faced with a student suicide, but we have had lots of self-harming, particularly by girls. Again, it has the potential to cause hysteria, especially amongst adolescent girls—they get very anxious and very upset. It is about getting teachers to deal with it rationally and calmly and to explain why somebody might need to self-harm. That is where our GP who visits the school has been invaluable over the years. She has occasionally come to staff meetings and spoken to the whole staff about why this might be happening amongst students, just to keep the situation calm and ensure it is dealt with in a very supportive manner.

Senator MOORE—I just want to ask about the visiting doctor and psychologist program. Is that state funded?

Ms Cowper—No, it is not.

Senator MOORE—How do you do that; is it Medicare funded? I am interested.

Ms Cowper—It is actually done with enormous goodwill from the Victor Medical Centre. We have a fairly proactive practice down there. The doctors have the understanding that if there is early intervention with adolescents then long-term, down the track, that will benefit in cost savings as well as life saving. They willingly allow one of their doctors to come and consult at the school. It took a little while to get the bulk billing system worked out but we have managed to get that done. The same goodwill applies to the psychologist as well.

Senator MOORE—So when the doctor comes in and sees a student, that comes under Medicare.

Ms Cowper—Yes.

Senator MOORE—Then, if they refer them to the psychologist, that comes under the Commonwealth funding.

Ms Cowper—That is right.

Senator MOORE—And that is part of a community process you have going?

Ms Cowper—It is. We were very lucky in that we won a Schools First award. We were one of five state finalists, I think. That has helped enormously. But we have actually made a decision that we are not going to use the money just to pay for an SSO to do the paperwork and those kinds of things. We have decided that we are going to use the money to try and promote the program because we really believe that it is something that all schools should have access to down the track. That is our ultimate dream.

Senator MOORE—I have never heard of it anywhere else. I am quite fascinated.

Ms Cowper—No, we are the only ones.

Senator MOORE—It is in no other schools in South Australia yet?

Ms Cowper—No.

Ms Zilm—For a while had a very close link with Mannum High School's GP, back in the earlier days of the project, but I cannot speak about where that is at the moment.

Senator MOORE—So the stimulus covers it—the stimulus comes from the supportive GP practice, who actually wanted to get involved.

Ms Zilm—Very much so.

Senator MOORE—It is fascinating.

Ms Pearman—Also, in other states and territories, a significant proportion of schools who are operating MindMatters as part of their process report that they have very close alliances with GP practices. We know that, for a schoolteacher to be leaving at the end of the day with a child on their mind and in their heart is not great. So we are working with schools to try and develop those pathways as to how they might do that—'Let's look at how we do that. Let's get your core team together, including your executive, your principal and your deputy. Let's work out the pathways so that we are caring for the staff and the students.'

Ms Zilm—And, with the MindMatters Plus demonstration project, we looked at what else you can do, after you have the MindMatters in place, for students with higher needs. There was a MindMatters Plus GP aspect, where we worked closely with divisions of general practice, and there are lots of wonderful examples of that not only across South Australia but across Australia. It was a case of opening both schools' and divisions' eyes to where that commonality is and to the fact that they can support each other and work together to make both jobs a little bit easier—probably in the long run also saving money and time—and to support young people in a more wraparound way, as Lindsey was describing.

Ms Cowper—I have to say, regarding Jill's comment, that, if our staff did not have this mindset of acceptance and understanding of mental health and how it affects young people, which has obviously come from MindMatters, getting that program into the school would not have been as seamless as it has been. It does have the potential to give the appearance that there is a problem in the school—'Why does the school need a doctor? Why does the school need a psychologist?' But, because our staff and leadership have the mindset that this is a proactive way of dealing with mental health in a positive way, it has worked very well.

Senator MOORE—You must have information, because you got the school prize, about this program.

Ms Cowper—Yes, I do—not with me it.

Senator MOORE—If we could get that separately that would be fabulous.

Ms Cowper—Absolutely.

Senator MOORE—The other thing is that the doctor’s work is linked only to mental health.

Ms Cowper—Totally to mental health, yes.

Senator MOORE—So that is an agreement. I ask because of privacy and that kind of thing.

Ms Cowper—Yes.

CHAIR—Thank you, Senator Moore. That was good because it covered one of the questions I was going to ask.

Senator ADAMS—Where does the chaplaincy program link in? Do you have a chaplain in the school?

Ms Cowper—Yes, we do have a chaplain in the school. In the time I have been there, we have had three different chaplains, and we have consistently sent our chaplains along to the MindMatters training as well. Our current chaplain has a focus on transition. Her focus is on working with the primary school, with years 6 and 7, to make sure that they have a seamless transition into high school. She was one of the key people that we sent along to the transitions module with MindMatters, which looks not just, obviously, at that kind of transition but at all transitions in young people’s lives. She is a part of that.

Ms Zilm—From a national level, we see chaplains as just one piece of the pie. We spend a lot of time building upon the resources that exist within the structure, system and local community and getting schools to work together. We are not in competition with any other thing that the school or the community is doing. It is about harnessing it all and making it work under a framework.

Ms Pearman—For example, just last week our officer in Tasmania conducted training for all the chaplains, both in the north and the south of the state. That is an ongoing part of our whole school approach.

Senator ADAMS—When a child goes to the GP, when do you bring the parents in?

Ms Cowper—Stating the obvious, that is on an individual, case-by-case basis. It can be from the initial consultation. It can be that the parent has contacted the school and said, ‘Look, I am really concerned,’ and the only way of getting the child to see the GP is to have their parent there. Then, at the opposite extreme, the parent is actually the problem.

Senator ADAMS—That is what I was thinking.

Ms Cowper—So the child will obviously see the GP initially, but both the GP and the psychologist have the ultimate aim of making it a process that involves the family, which it is realistically the only way that an issue can be resolved.

CHAIR—Do you need parental approval?

Ms Cowper—Yes, we do. I am pretty sure that is up to the age of 15. But, if the parent is actually the problem, the GP—after they have contacted legal, risk et cetera—can manage a first consultation with the child alone. There is a guarantee that the parent will be involved eventually. That has to be done very carefully, obviously, because of the ethics involved.

Ms Zilm—Before we finish, I would like to share the work we have done with Indigenous communities as well, if you are interested.

Senator ADAMS—I would be very interested to hear what you have to say about that.

Ms Zilm—Because MindMatters is about a process, a way of working and a lens through which to view things, we have some wonderful examples of the inroads that we have made in Indigenous communities. Here in South Australia, over the last five years we have worked with the Pitjantjatjara-Yankunytjatjara community in really culturally sensitive and empowering ways. Their MindMatters work, if you like, about child protection, mental health, wellbeing and all of those aspects is now being delivered by the Aboriginal education workers. It has become an incredibly community focused approach, with the entire community, including the elders, on board. They have a symbol, a strength tree, that represents what they are doing in their community.

It includes translating our resources into Pitjantjatjara language, and in ways that young people connect with. They recently went to Alice Springs to share the process that they have used, with MindMatters support. It has been sustainable, and our involvement in it is now just occasionally to help them develop further. The traditional owners in Central Australia were part of hearing about that process, and they have agreed that with the rent moneys they get from Uluru, rather than buying second-hand cars, which is where the money has gone to over the last few years, they will invest $60,000 in bringing that same approach—that process—into their community.

Senator MOORE—Is that in the school?

Ms Zilm—When they talk about community they are talking about their school as part of that community.

Senator MOORE—But you operate with the school network.

Ms Zilm—Through the school.

Senator MOORE—I just wanted to get that.

Ms Zilm—Yes, it becomes the focal point. We have lots of other examples. In Tamworth in New South Wales there is a men’s group who deliver what we would call an aspect of MindMatters training called ‘Feeling deadly not shame’ with Indigenous youth. They have branched out to do things like talking about what happens if you come across a mate who is threatening to harm himself, for example. It goes to the pointy end.

In Queensland, Moreton Indigenous leaders are using MindMatters to develop strengths in young Aboriginal people who then go back to their schools. Our projects officers work with the schools so it all becomes supportive.

Just today, our South Australian project officer is heading out to Murray Bridge. Raukkan is an Aboriginal community just outside Murray Bridge where they are developing a new community school for kids who have disengaged from school. They are establishing this—this is green fields—based on the MindMatters level 2 process, to make sure they get things right. They are just a few examples of inroads that we have made. I think we have got respect from those communities about the way we engage them in authentic ways and empower them to take it forward. That has been one of the answers in delivering their child protection curriculum, for example. It is very important stuff.

CHAIR——Do you have any further information on those programs? I am not going to try to make you do extra work. I was just wondering whether you already had some information you could give us. That would be—

Ms Zilm—Specifically on each of those Indigenous ones?

CHAIR—Yes; is that possible?

Ms Zilm—Yes.

CHAIR—It would be much appreciated if you could do that.

Ms Zilm—How would you like that—hard copy or electronic?

CHAIR—If you could send that electronically to the secretariat that would be great.

Ms Pearman—Could I make one quick comment about that? In terms of the way MindMatters works, when we talk about the whole school we are talking about the curriculum within the classroom, and in teaching and learning we are talking about the partnerships that a school has. That is quite hard to define for a school, because sometimes schools sit like this. We have really put a lot of energy into opening that up and many of our MindMatters schools are finding so much strength from the partnerships that they have happening. It is really making a difference for the kids on the ground.

One deputy from one such school in Sydney provided me an example just recently. She said her school suspension figures for students had reduced and retention figures were up. School attendance was up and staff reported that support for them is significant when dealing with students at risk. That is a very important aspect, because staff health and wellbeing, we know from research that we have done through the Hunter Institute of Mental Health—we commissioned them to do a scope to see what were the risk and protective factors for staff—we learnt that those staff working with students with high needs were, themselves, quite at risk. We know that, so this is something else that is in our sights. While taking our staff with us in terms of understanding the concept there is also quite a lot of work that we do in terms of looking after them so that they, in turn, can look after the kids. There is a sort of pronged approach that goes across.

Senator MOORE—Can we also get some information about the headspace partnership?

Ms Zilm—Absolutely.

Senator MOORE—To have that would be good.

CHAIR—I want to go back to this issue of working with GPs. I would like to see that copied in other places. You started touching on the concept of working with the Divisions of General Practice. I know there is going to be a state of flux when we are looking at the health reform issues but whatever organisation takes their place it is still the same point. It seems to me that that is a point of entry to working with GPs. Divisions of General Practice get funded through specific programs and if we could have them taking a lead it seems to me that it would be a useful way to proceed. You started touching on that issue. How much work have you done, in general, with Divisions of General Practice?

Ms Zilm—Our project officers are involved in some ongoing work in different places around Australia. For example, we have a reference group in each state and territory, and some divisions of general practice are on our reference group to keep in touch and look at ways of working together. But the work we did through MindMatters Plus GP arm ended up with some resources that are being used by divisions. But it varies across Australia. One of the interesting findings, I think, was for divisions to realise that the MindMatters curriculum was actually providing things that, in their heads, they saw GPs going into schools and teaching lessons about. But we were saying, ‘No, we’ve got that covered; teachers do that.’ The GPs can play a role in the way described by Victor Harbor. They are there to do the work that teachers cannot do and are not skilled to do. So it is that continuum, and I think that was a big finding. That has gone on to be operational in varying degrees across Australia. The demonstration project only went for a couple of years. We have an evaluation of it.

CHAIR—Could you make that evaluation available as well?

Ms Zilm—Yes.

CHAIR—Talking about general issues around mental health, I have noticed varying degrees of engagement by various divisions around Australia. Some divisions seem to be fantastic, but for others it is very patchy. So I would be interested to see your evaluation so we can see if there are some other areas where we could recommend a way forward in terms of divisions of general practice engaging more. Obviously, we have not yet gone to what we are going to recommend, but it seems to me that that would be helpful.

Senator MOORE—Can we go to funding now. There was MindMatters and then there was MindMatters Plus. Can we get on record what is happening with the funding. That is so important.

Ms Pearman—As I said, we have been funded since 2000. Our current contract concludes in June. However, we are in negotiations with the department over an extension till December. We have negotiations over a further contract, which we hope will be a two- to three-year contract, and that will obviously have headspace working closely with us.

Senator MOORE—There was a lot of discussion around aspects of the 16 demonstration sites. Other schools in other areas are really interested in what is happening in those extended programs. What is the current status of the funding for the wider aspects of MindMatters that were in the demonstration sites?

Ms Pearman—What are you referring to?

Senator MOORE—The partnerships and the focus and the special help that was MindMatters Plus.

Ms Zilm—That project was for a defined period of time. That is now over and the evaluation has been done . The findings from that are what have driven our development into what we refer to as the level 2 process.

Senator MOORE—That is what I was not sure of.

Ms Zilm—We focus on students with high needs, we focus on links with divisions and all that sort of stuff that came out of it.

CHAIR—So you are negotiating an extension till December. Is the continuation of MindMatters Plus level 2 part of the ongoing negotiations?

Ms Pearman—Yes. When MindMatters originally came out, we just had level 1, which was bringing to life the kit. Then, based on the evaluations, the findings from that, we developed, in consultation with others, level 2 and its process. So there is a level 2 planning workshop. Student support needs to be a focus with a mental health lens. There are nine modules looking at all of the issues, including student empowerment and transitions, which Lindsey mentioned.

CHAIR—You look at the pyramid?

Ms Pearman—Correct. So what we are seeing is that staff continually come to level 1. We know that populations in schools change all the time. They continuously roll through level 1. They bring their executive along with their wellbeing team to level 2 and they are sending a variety of different staff across to all of these modules. So you end up having a whole lot of staff, across the school, trained in different aspects: transitions, with a mental health lens; students experiencing high support needs, which is the lens; student empowerment; communities do matter, the work that Tracy was speaking about, with Indigenous Australians; and all other different aspects. And then you have that process. We have incorporated that evaluation and the learnings from MindMatters GP Plus Divisions and carried that into there.

CHAIR—Into what you are now negotiating with the department?

Ms Pearman—Correct—into what we currently offer, which we believe is very comprehensive.

CHAIR—So it would be about all of that. So, in effect, the special project that you had, MindMatters Plus, becomes core business?

Ms Pearman—Yes. We took learnings from it and it became part of core business. In addition to that, it is very important to mention KidsMatter. From reading some of the *Hansard*, I think it has come up in evidence. So what we have with KidsMatter and MindMatters is a K-12 initiative which is very comprehensive in its framework. Of course, KidsMatter is the primary focus. It is initiated and operated through Principals Australia but with partner organisations the Australian Psychological Society and beyondblue. Again, the feedback is that it is a fantastic framework. It is rolling out across Australia in a whole variety of ways after its pilot. Again it is a very interesting lens for people to put on the work they are doing. So, hopefully, we are offering something which is fairly comprehensive.

Senator WORTLEY—So it is a whole-of-curriculum approach right across the board. Is there any specific classroom time dedicated to the program in individual classrooms?

Ms Zilm—Yes, and that varies across schools. One of the other aspects of MindMatters is that it is so important to work in with what schools have. If you try to come in and impose something, all sorts of things happen. Some schools have almost MindMatters lessons. Other schools have a mentoring approach where you deal with those issues. Other schools will blend in aspects of what is on offer in our curriculum—this piece will sit in English, this piece will sit in drama and this piece will sit in the health program—and put it in in a whole lot of ways. We work closely with schools. We say: ‘You need to map. It needs to be there. How it gets there can be determined by your school, but you need to know that all kids, over time, are being cycled through understanding all of these issues.’

Ms Pearman—And the other issue that is very important to mention is that we are working with schools to help them develop data driven plans, because they have to be working from what they know. The Australian Council of Education Research and MindMatters have put together a series of questionnaires, and the data is on our website. The schools can access that. It is for staff, students and parents. They can monitor that and look at what is going on over time. You need to know whether something is working or not working, and, if it is not, you change tack. That is the model that is in your kit. It explains what we are trying to create. We are trying to create a continuous connection for the young person so that they feel connected at all times in all things they do.

Ms Zilm—That data is driven by Sheree Vertigan, the principal at Reece High School in Tasmania. She talks about using MindMatters and the youth empowerment process since 2006. At the end of 2009 they did an evaluation. Student empowerment is the centre of their work, but they also had an increase in mental health promotion, a reduction in the stigma around mental health, an increase in self-referral or referral of peers or family members to their school psychologist and a decrease in explosive or unexpected student behaviours. We are getting schools to monitor this. It is important to know whether you are having an impact; otherwise, you are wasting your time and your money.

Ms Pearman—Those stories are common. The difficulty is in capturing all of them.

Ms Cowper—What we are aiming to do with my own school is to get all of our staff to have a specific mindset. The biggest difference between primary schools and secondary schools is that primary schools actually see themselves as teaching the children; unfortunately, a lot of high school teachers still have the mindset that they are teaching the subject. We are working really hard to change that. We are working hard with math teachers, science teachers, PE teachers et cetera to understand that they are working with the whole child and when they walk into their maths class the child's wellbeing is still important. So if a child is sitting with their head on the desk, they will not say, 'That is their problem; they not going to get what they need out of my lesson today.' Instead, they will stop and think about why the child is like that. So we try and have that mindset and lens, which we talked about before, where teachers can look beyond their subject. Also, during mentoring time, the teachers, with that broader mindset, can teach the MindMatters kids as well.

CHAIR—Thank you. You can probably tell that we could go on all afternoon!

Ms Pearman—And so could we!

CHAIR—I think we have given you a little bit of homework, but hopefully it is just about sending us some information; I do not want you to have to do a whole lot of work for us. If you can send that additional information it would be really appreciated. Thank you very much. As you can tell, we are fascinated and very engaged.

Ms Pearman—We did intend to put in a written submission which we are working on. Would that still be valuable?

CHAIR—Yes, definitely.

Ms Zilm—Thank you for giving us the time. That is something we value very much.

CHAIR—Thank you.

Proceedings suspended from 12.55 pm to 1.36 pm

WEBSTER, Professor Ian William, Private capacity

CHAIR—Welcome. Would you please state the capacity in which you appear.

Prof. Webster—I am a physician and an emeritus professor of public health and community medicine at the University of New South Wales.

CHAIR—You have received information on parliamentary privilege and the protection of witnesses and evidence.

Prof. Webster—Yes.

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

Prof. Webster—I thank the committee for the opportunity to make this presentation and, like many people in Australia, I welcome the Senate's interest in mental health and social well-being. The submission that I made to the inquiry was made independently but comes from my experience in medicine and in public health and my involvement with non-government and government organisations and also over a period of time as chair of the advisory committees that have existed at the Commonwealth level about suicide prevention. In my opening statement I want to be fairly broad in what I say and set the context for the development of suicide prevention. Also, Chair, I would like to invite the senators to meet with the members of the National Suicide Prevention Advisory Council if that is possible to arrange. It probably would be useful for both parties and certainly, I hope, for the senators if that could happen.

CHAIR—We would certainly welcome the invitation and be keen to find a time that we could do that.

Prof. Webster—The national concern about suicide and suicide prevention started in Australia in the late nineties. At that time the rates of youth suicide were increasing and Australia was one of the first countries to pick up the idea of establishing a national suicide prevention program. That had been recommended by the United Nations in 1996, and we did this well before the United States, the United Kingdom and very many other countries. In fact, Canada, which is a comparable country to our own, is still to do something like this. The Australian initiatives in 1995 started initially with a program called Here For Life, which was a national plan for youth in distress, and later that year the government established the National Youth Suicide Prevention Strategy. I should point out that the Western Australian government started many of these ideas earlier than at a national level. The Western Australian government had appointed a youth suicide advisory committee in 1989.

Because of the complexity of suicide and trying to understand its causation and what could be done about it, and there was very little guidance and advice about what worked and what had been evaluated anywhere much in the world, the government of the day appointed an advisory committee. This is going back to the youth suicide period but I would say the same is happening even now. This was a group of people who represented a range of interests, including professional interests, in those early days businessmen. For example, Lindsay Fox was a member of the original committee, Mr Michael Perrett, who is an industrialist from Western Australia, Mr McGrath, who came from Warrnambool in Victoria and was the chairman at that time of the Mental Health Advisory Council. It also included representatives of the community. The idea was that that committee could weigh up the evidence and advise governments about what would be worth while to attempt at that time. There were also other mechanisms in place then. There was an advisory process which specifically involved representatives of the community and experts, and each of the states had advisory processes.

The national action plan for suicide prevention commenced in 1998 and that plan was developed by the Suicide Prevention Council I have just been speaking to you about. That was a time in which the LIFE Framework, which I understand you have had copies presented to you and even had a little microchip with it on presented to you. That is Living is for Everyone, and that was first disseminated in 2001. When it was initially developed it was an attempt to provide guidance both for government and for non-government civil society organisations about the sorts of things that could be addressed and to invite partnerships across the country in suicide prevention. It was not a strategy in the sense that governments define a strategy and put benchmarks against it and specific funding programs. It was an attempt to set a framework for people to do their work in many different settings. That LIFE Framework has been extensively used. It has been updated about two years ago. It forms the basis for the way state governments construct their suicide prevention strategies.

I think governments at that time conceived of suicide prevention as being a broad public health approach and a community development approach. In the earlier days, which was the days of the Howard government, there was a very strong emphasis on community-based programs and less engagement with the public sector, but in the recent iterations of the strategy with the present government there is a much clearer national framework and program under mental health and more definitive negotiations taking place with state governments. Many projects and programs have been funded across Australia, and I note that many of them have presented to you in different ways.

The initial and continuing idea of the funding program, which was a relatively small bucket of money—in those days initially it was $10 million a year—was to fund national projects and community-based projects. As I mentioned, there was an interest in the government of the day in community-based projects. Indeed, the Prime Minister of the day had a very strong interest in what would happen with those projects. Of more recent times there has been refinement of that and, as a result of the evaluations and advice and with experience with the program, the funding has been more focused and targeted than previously. Every funded project was expected to undertake an evaluation and was required to evaluate against agreed objectives. There was an evaluation booklet which was prepared during that period of time which was given to each of the organisations or groups conducting suicide prevention to assist them to develop their ways of evaluation and how to report on it. These individual evaluations and evaluations at a higher level have shaped the National Suicide Prevention Strategy.

Also in those early days there was an emphasis on resilient, protective, universal programs of the type that you have had presented to you just before my appearance—the mindframe initiative—but, as I mentioned a moment ago, there is currently a stronger focus on high-risk groups.

Some of the major influences which I think have contributed to the reduction in suicide rates in Australia have included domains which come outside the conventional constructs of mental illness and mental health. I think some of the most important achievements in Australia have been related to mental health. With respect to public awareness of mental health and risk factors related to depression and suicide I think we have come an enormous distance in the last decade. There is more balanced and enlightened public media discussion of issues relating to suicide and to mental health in its broader sense. There has been much greater involvement of consumers and advocate organisations in the mental health field and in suicide prevention and a greater awareness of suicide in community based organisations. In fact, that has been an important area where funding has been applied during the last decade.

I also want to make the point—and it was made by Professor Harrison earlier—that there have been important contributions by areas outside mental health—that is, the making it difficult for barbiturates to be prescribed in Australia which led to a decline in suicide rates in the seventies and early eighties. The gun control initiatives, which resulted from the gun buyback scheme, have made a significant contribution to a decline not only in deaths generally from gunshot but also in suicide. There has been a reduction in carbon monoxide emissions in Australia from the motor car fleet because the fleet has been changing to European standards. There has been declining illicit and related drug use in Australia. Some of those early increases in suicide in young people paralleled very closely, but were probably independent of, the rising overdose deaths from illicit drugs at that time. Studies have been undertaken on those cohort effects, published by the National Drug and Alcohol Research Centre. There have been reductions in overall alcohol consumption but in the high-risk groups consumption of alcohol is still a problem.

I think a very important achievement, which I note the committee was exploring in the last presentation, was that there has been a greater involvement of primary care practitioners and general practitioners in mental health and in suicide prevention, compared with a decade ago when general practitioners generally were not that engaged in mental health issues. There is an interest in mental health in divisions of general practice and amongst many general practitioners and there is of course special funding to encourage that. I think that has been a remarkable change. Possibly another effect has been the increased access to effective treatment of depression.

Of course, during this period people have wanted to know how well we have been travelling and have attempted to evaluate what has been taking place. I have already indicated that each of the projects was expected to evaluate what they did and the subsequent funding depended on the adequacy of those evaluations. But you will be aware there is generally a criticism of the rigour of evaluations generally in this field. However, I would like to make the point that it is not an easy task to evaluate broad, social health programs. Professor Harrison made the point to you earlier that, in terms of epidemiological studies looking for interventions and effect, the outcome of suicide is a pretty rare event and it is hard to show statistically that what has been done will show a change. We need to have ways of appreciating and understanding these broadly based programs by government and by society, which include a range of dimensions in making those judgments. They do not necessarily lend themselves to some of the linear evaluations that some of my academic colleagues may demand.

So since the 1990s, at different points of the suicide prevention strategy, there have been evaluations of components of it. Some of the early evaluations were published in a series of books called *Valuing young lives*, published by the Australian Institute of Family Studies, and the author was Dr Penny Mitchell. That pointed to those early developments in suicide prevention and described what I have described to you of the broad-based public health approach, with the emphasis on increasing capacity of communities to develop their local responses to youth suicide at the time.

During that period of time, the department of finance and Treasury had expected these programs to be evaluated according to what is described as program logic. That has been a constraint on the way these programs have been evaluated. But there have been some good examples where the program logic approach has been developed. With funding from the national strategy, a program logic set of evaluations was introduced into the Victorian initiatives. This was developed by the Centre for Development and Innovation in Health at the Australian Institute for Primary Care at La Trobe University. As a committee, you have already received some information about the 2005 evaluations done by Urbis Keys Young, which have informed some of the change in focus of the current strategy. The Commonwealth government presently is proceeding to develop an evaluation of the more recent developments.

Finally, I want to make, to me, an important point. Many people have made the point to you that suicide is the worst outcome for mental illness. But it is also the worst outcome for other circumstances where people are marginalised and socially segregated, when people have chronic pain, when people have chronic physical illness and when people have diminishing mental capacity and progressive disablement. As a physician, they are the sorts of problems I see frequently. In the environment of drugs and alcohol and in dealing with people’s chronic pain, and I look after very many people with chronic pain, there would hardly be a consultation that I have in which the issue of suicide and suicide risk is not discussed. So suicide can be and often is the outcome of intolerable suffering.

And there is one other set of comments I want to make. In looking at your terms of reference, I think it is important for the committee to look a bit beyond the way those terms of reference have been defined. One of the most important things in relation to suicide prevention is the issue of social support and relationships and communities which governments can facilitate, but they cannot necessarily do—for example, such programs as the government’s interest in ‘social inclusion’ and closing the gap of Indigenous people. I have made a point already, and I think Professor Harrison made the point, and indeed the recent *Medical Journal of Australia*—I table this for your interest, but you may have already have seen it. It is an article called ‘Suicide in Australia’ and the *Medical Journal of Australia* really makes the point that the decline in rates of suicide in most parts of Australia coincides with the reduction in the availability of lethal methods, so it is the idea of being concerned about what it is that people have access to when they are at that critical point of risk.

Suicide prevention involves all branches of health and social systems. For example, in health care the issue of suicide assessment and suicide prevention should not be seen only as the task of a mental health service but should be seen as the bread and butter or built into the approach of drug and alcohol clinics, rehabilitation clinics, pain clinics, the care of elderly people, and the like. It is not a problem confined to mental illness, albeit that it is extremely important and of great significance to society. I certainly support the emphasis that is being placed on giving a high priority to mental health. My experience as a doctor over many years is that mental health has not been highly regarded professionally or within the systems in which many of us work. That is my opening statement. Thank you for the opportunity to make it.

Senator MOORE—Professor, there are so many things we would like to talk about and we are always limited by time. I want to focus a little bit on the current system and how it operates. I am looking for your opinion, and you may or may not be able to comment. One of the things that bedevils the current funding arrangements is, in my opinion, the tender process. We have had a lot of evidence from people from across different parts of the country who say that they want services that are local. They want things that relate to their own needs and engage local people. Health, as with a number of other agencies, operate nearly all their funding rounds on a tender basis, which tends to, in my opinion, favour large organisations that have the ability to write good tender documents. There is tension between large organisations, like Relationships Australia—and I was hoping they were there; I am using them as an example because they are here today—who have a big spread and can write and get tender results all over the place, and then they have to go about forming local partnerships. Is that something that you have seen? How do we work with that?

Prof. Webster—Absolutely. I agree with you. I do not like the current processes—the way funding is managed—but that seems to be a structure that government has developed right across the board. I was reflecting on the early days. In the early days people from anywhere could write submissions. In fact, the committee that I am involved with was involved in the process of assessing them. These days they are assessed by separate groups, with issues of probity oversighting them and a whole set of things which are somewhat foreign to the idea that you are discussing. The early experience with that was that there were lots of submissions and lots of disappointed people and there was not much money.

There were some very innovative approaches in some places. Queensland went through a process of expressions of interest from the community and then selections were made. South Australia—I am talking about six or seven years ago—said, ‘There is a bucket of money which the government is allocating under the Suicide Prevention Strategy. We think we could use it differently. We will define three areas of South Australia—around the top of the Spencer Gulf, some of the northern suburbs of Adelaide and’—I hope I am right—‘the Murray Bridge area.’ There were three areas which, by social indicators, were defined as areas of high risk. The state advisory body, which could recommend on this funding, went to those communities, put advertisements in the newspapers and said, ‘As a community, you could get organisations to come together and propose a program.’ That was done in South Australia. Although I cannot recall the formal evaluations, evaluations were done of that process. So we had three different ways of doing it. I rather like the one that South Australia did. Other things have taken over since then. It is difficult. The pressure on the Suicide Prevention Strategy is to focus on so-called evidence based interventions and yet communities cannot demonstrate that.

On the other side, you can hear lots of presentations. The ABC had a very good program on *Background Briefing* a few months ago. The ABC journalist had been to Canada and many different countries. It was about rural suicide being developed out of the communities. Brian Kelly, who has given evidence to you at some point and is an expert in rural health, was a commentator on that. I think that is a problem for government. All sides of politics recognise that communities are important. The conservative side see them as important for one reason, and the more progressive sides have an emphasis on community too. But, with the increasing focus, I think that is disappearing.

Senator MOORE—It is the sense of local ownership. We heard this morning from a group who have a history—and we will be talking about that with other people—but do not seem to be able to fit into the box. The system has created boxes for the way things work, and if you do not fit you are not eligible for funding.

Prof. Webster—That is right.

Senator MOORE—I think that is something we should be looking at. I do not know the answer, but I think it is important that, in groups like the one which you chair, at least that process is acknowledged.

Prof. Webster—I certainly acknowledge it. I think we lose a lot by tightening up the criteria so that those community organisations cannot get funding.

Senator ADAMS—I would like to know about your experience of Indigenous communities with the programs and how they are working.

Prof. Webster—We have not done very well with suicide prevention in Indigenous communities. Presently there is an Indigenous Strategies Working Group, which will help us define how we should respond to Indigenous communities.

CHAIR—Who is organising that?

Prof. Webster—It is part of our group. It is called the Indigenous Strategies Working Group, which was an offshoot of the Suicide Prevention Advisory Council but it has now been elevated within the department and it involves the Mental Health Council as an advisory group to the government about how to respond on mental health and suicide issues.

There was a presenter earlier today from Tasmania talking about the conceptions that communities have of mental health. He was arguing that communities were more comfortable using terms like ‘wellbeing’ and ‘social wellbeing’. Aboriginal people—over the period of the last decade that I have been involved in this process—do not use the term ‘mental health’ either. The programs that were run for Aboriginal communities with which they identified were defined as social and emotional wellbeing programs. If you went to an Aboriginal community to talk to them about suicide, in the next breath they would be talking to you about alcohol. So I think the formal language that we use in defining our programs does not fit very well with the way Indigenous people construct their responses.

There have been good examples where in certain communities suicide prevention initiatives have been extraordinarily effective. Yarrabah in Queensland is an example of that. I have been involved in alcohol interventions in Indigenous communities, and these things overlap greatly. It is when they can work together and define the problem in their terms that they best work.

One of the funding arrangements made by the federal government over this period of time was to appoint what were called life promotion officers in the Northern Territory, Queensland and

Western Australia. These were usually identified with Indigenous communities, and they developed strong standing and influence in those communities. I confess now that I am not sure what has happened to that program.

In East Arnhem Land, beyondblue developed, with the Commonwealth government and the Top End Division of General Practice, what I regard as an outstanding project or program for mental health in those remote Indigenous communities. I will quickly describe it. An Aboriginal leader was identified—it might have been a male or a female, or a male and a female. That person went to Batchelor College and got some basic training in mental health. That person was supported by a coordinator—a remarkable young woman who is still working with Indigenous communities—who was employed by the Top End Division of General Practice. These people who had special training would be identified in their communities as people to whom the community could go to, or who had identified the problem in their community—of cannabis use or whatever was the big problem—and when the nurses and the medical officers came in they could broker relationships between the community and the formal health services. The reason I got involved with it was that the Alcohol Education and Rehabilitation Foundation put a lot of funds into it too, because it was identified that alcohol was part of the mental health problem.

We really have a long way to go. Hopefully, some of the initiatives of the Commonwealth government will now make a difference, but as I think Professor Harrison said, the rate of suicide in Indigenous communities is high, and the evidence is that it is increasing in young Indigenous men.

Senator ADAMS—Just onto the issue of under-reporting, you noted here the ABS report on suicides, which was released on 31 March 2010, estimating that in 2007 the under-reporting was of the order of nine per cent. We have been getting all sorts of figures as we have gone on, asking this specific question. Could you help us with that?

Prof. Webster—I am not an expert in that aspect of causation of death and death certification, although I have been a pathologist and I have done lots of autopsies as a younger doctor. I do know that determining cause of death is problematic, not only in this area but in other causes of death. There are formal studies showing the mismatch between the medical certificate and the actual cause of death. I cannot report the relationship but it is not a very good one.

I was surprised to learn, about three years ago, that there is a significant discrepancy. I have always assumed that ABS was the benchmark. I quoted Robert Goldney, and I noticed that somebody else earlier today quoted Robert Goldney to you, too. He makes the point—I think most people make this point—that under-reporting and difficulties of reporting are inherent in the nature of determination of suicide. Intent and lots of different things affect it. But we recognise that there is an increase in under-reporting, from the evidence in Queensland and from that ABS data and other work.

I think that Australia is taking appropriate steps to remedy that. The question, though, is: will that alter the directions and focus of suicide prevention? I think many people have said to you that it would. I am uncertain about that, but broadly speaking the risk groups that we have identified in Australia are parallel to and consistent with the risk groups that have been found in most other countries, as I understand it.

The Australian Suicide Prevention Advisory Council has commissioned a number of projects to try and refine some of these issues of risk and I have a report here which we have received recently from the suicide prevention research group in Brisbane, AISRAP, which is a research centre of excellence in suicide prevention, on the epidemiological evidence of who are at high risk, but they are they same as those who have been reported to you.

We are doing a major study that asks: which are the groups in rural communities that are at the highest risk? It is all very well to say there are higher rates in rural communities, but which parts of the community are particularly at risk? That will enable the government to focus more appropriately on those who are most at risk in rural areas.

I do not think I have much more to report about the under-reporting, although I did make the point in my paper—and I think someone was making the point to you earlier today—that, over the last decade, parallel phenomena such as gunshot deaths, homicide deaths, drug overdose deaths and deaths due to illicit drug use have all declined. So there are lots of changes that are consistent with my view that the suicide rate in Australia has been falling. When you look at arguments about causation, one of the things you have to do is look at evidence that is congruent with other phenomena, and I think the fact that suicide rates are declining is congruent with many other parallel observations of both harmful practices in our society and deaths from other causes in our society.

CHAIR—We have just about run out of time but I have a question about the Indigenous Strategies Working Group. As I understand it, the Suicide Prevention Council and the Mental Health Council home set this process up. Is that correct?

Prof. Webster—Yes. It was initially set up by the Suicide Prevention Council. The person who chairs it is a member of our council and she has now been appointed to the National Advisory Council on Mental Health. So it is appropriate that it is a joint process. Also, the Aboriginal people themselves wanted it to be more broadly based. It initially arose from suicide prevention some years ago. There was a remarkable project that they oversighted initially. But, disappointingly, a couple of those projects petered out. In one of them, young Aboriginal people were going to be lined up with older Aboriginal people, women in particular, to write stories about suicide together. It would have been a very appropriate conjunction: the older women, with their knowledge, and the younger women with their capacity to use computers and teach the older women about how to write things up. In fact, money was given to those groups, and some of the older Aboriginal women involved in that used the money to go to the local doctor and ask for his time so that he could explain to them various terms and aspects of mental health. That project, I thought, had great potential. But it petered out, and the reasons for that I am not certain about.

There was another very important project six or seven years ago which involved Suicide Prevention Australia, SPA, the National Aboriginal Community Controlled Organisations and the government of Western Australia. This was to establish a project called ‘Community Life’. The idea was that it was going to be a halfway house in Australia for information and support—a place where community organisations could go and get advice or look at what had been done in other places. Again, I thought that had great potential, but, in the end, it failed. Again, I am uncertain of the reasons, but it had to do with the relationships of organisations. That is all I can say about it at this stage.

Senator MOORE—And that was six or seven years ago?

Prof. Webster—Yes, that was about six or seven years ago, and SPAA and the government of Western Australia—

CHAIR—We have run out of time, as is usual.

Prof. Webster—As I said, we would very much like that as a joint discussion sometime.

CHAIR—We would very much like that too, and I know that the secretariat is onto organising things so we look forward to that, thank you. I think it would be very, very useful for us.

[2.16 pm]

RALFS, Ms Claire, Director of Services, Relationships Australia, South Australia

RAY, Ms Mergho, Senior Manager, Primary Health Services, Training and Education, Relationships Australia

CHAIR—Thank you for coming. I understand that both of you would have been given the information on parliamentary privilege and the protection of witnesses and evidence.

Ms Ralfs—I think that is what came in the letter.

CHAIR—Right. We have your submission and I would like to invite you to make an opening statement, if you feel that you want to, and then we will ask you some questions.

Ms Ralfs—Thank you for your time and thank you for your inquiry. I took the opportunity to put this submission in because it is not an uncommon thing in our experience. We do two things. We have a program called SQUARE, suicide, questions, answers and resources—and I cannot remember how that acronym works now. It is a suicide prevention, Commonwealth funded program where we teach a whole lot of suicide prevention training. Then we have a whole lot of family services, and of course we have trained our own staff.

But when we are intensively involved in a case that we are all seriously worried may end in suicide, how we relate to the acute services continues to be a problem. This then leaves me with a dilemma about what we are teaching the community sector to do. If we are telling them to do all of these things and then when they do them they do not work, we are concerned, and I guess that is what prompted this submission.

CHAIR—Do you want to expand on that now or do you want to leave it until questions?

Ms Ralfs—That is up to you really. You tell me your process.

CHAIR—Ms Ray, do you have any other comments to make?

Ms Ray—Not at this stage, thanks.

Senator ADAMS—Earlier we had some information from MindMatters of an example of how the schools fitted into that program and the divisions of general practice. I would just like you to tell me about the partnerships within the health services that you work within, and also with the schools and family relationships if you work with the schools—

Ms Ralfs—No, we are not school oriented. We are a family service. We are mostly Commonwealth funded—that is, 60 per cent of our services are Commonwealth funded through FaHCSIA—and we are mostly in post-separation and relationships counselling and child contact services. The SQUARE program that I referred to was funded by the Commonwealth Suicide Prevention Strategy; there was a mixture of state and Commonwealth funding. We developed training with what was then called SADI—they have changed their name, haven't they?—the South Australian division of GPs. It was a training program for the community, GPs and the community health sector. That program has a website. It was developed through similar sorts of funding as MindMatters. One of our writers, in developing that program, also worked on the development of MindMatters. So we are certainly aware of that training program. It is coming through the same sources, except our focus is the community and professionals. Does that make sense?

Senator ADAMS—The reason I asked about the children is that I was trying to see, given that there are often children involved in the issues that you deal with, just where they fit into the picture and how you partner with people to refer on problems. That was really why I asked the question.

Ms Ralfs—We have a whole complicated set of referrals. These include internal referrals because we have children specific services, particularly post-separation services oriented around the trauma of family breakdown and domestic violence. In South Australia we have an iKiDs program that specialises in that. People come to our service via a range of services and we refer some internally, but we also have arrangements with United Care Wesley and Centacare for various mixtures of education, counselling and home visiting services.

CHAIR—Support services.

Ms Ralfs—Yes. We are oriented around family services. I guess that was the other point in our submission: we are at the end where we see that domestic violence, gambling and child sexual assault are issues sitting under a lot of what we see as suicide ideation. We see that the suicide is a symptom of a whole range of things that have gone wrong in people's lives that are not necessarily attended to. That was one of the other points in our submission. I do not know whether I am answering your questions adequately at all.

Senator ADAMS—It was just that I was thinking that children, especially teenagers, with that problem might be very vulnerable to ending their lives. I was just trying to see how it all fitted in with the schools—whether they were or were not going to school—because that would come up in your area, I am sure.

Ms Ralfs—We would refer a teenager we were worried about to Uniting Care Wesley, because they have specialist services in relation to that.

Ms Ray—CAMHS also is certainly on our referral list, but you might also be aware that trying to get into CAMHS is hard. At times with our work there have been some collaborations with CAMHS. If there is already engagement with the young person through our service then certainly we can collaborate with CAMHS, but for CAMHS to take on a client from our service is hard. The client will get an initial assessment but then, depending on how they are assessed, they will sometimes sit on a long waiting list and then come back to our service. What could be improved is the time to collaborate and us keeping the young person engaged to work through any issues around suicide. Young people will say: 'That's it. I've had enough. I don't know what to do with the tension. I don't know what to do with the conflict.' So an increase in collaboration would be good. If there were really a quite strong pathway there—so that a client could remain in one service yet have issues that would normally be seen as CAMHS issues dealt with through a pathway—that would really enhance the number of people, who are quite desperate, that could be seen.

Senator ADAMS—Do you have anything to do with community training in rural and remote communities?

Ms Ralfs—Yes, we have quite a lot to do with it—that is part of the reason we have put the SQUARE programs on a website. A lot of the resources in relation to it are on a website and there are training things you can do from that website. Just before the Victorian fires we were contracted, weirdly, for that rural region—it is one of those cross-state-boundaries things and we still do not really know how it happened. We had just trained a whole lot of their community workers in our SQUARE program when the Victorian bushfires broke out. That is one of our rural processes. We also have quite a few APY programs, particularly Aboriginal youth worker training programs. We have put all of those sorts of materials through that sort of remote program as well. We do quite a bit of training and we are also one of the largest mental health first aid training deliverers. Hence my awareness that when you do it as a service you do what you say you are teaching people to do and then you come up against the same roadblocks. We are out there telling people what to do in relation to suicide prevention and then when we do it we come across things that we want to talk about to your inquiry.

CHAIR—What are the issues that you have come across when you start implementing your program? Where are the roadblocks and how long have they been in place?

Ms Ralfs—I do not think it is any one worker or system’s fault—I want to be really clear about that. I think it is a practice that we have yet to develop, which I want to emphasise. Can I speak about it in relation to cases? I think that is going to be more tangible.

CHAIR—Yes.

Ms Ralfs—One of the cases we wrote about in here involved a woman who had been referred to us by a hospital. She had been in a locked ward for five or six weeks. A lot of the issues for her had to do with a relationship breakdown, so she was referred to our service. We put in a community safety plan for her, I held family support members meetings and we had strategies. She did not have her mobile phone or keys, so basically she was escorted to work and was picked up and escorted home because she had seriously attempted to kill herself several times. The hospital felt that she needed to be at work as a distraction from her issues. We were doing all that and it was going quite well. It was quite intensive, as you can imagine. Then one day she disappears—she just leaves work. Work thinks that she has gone home sick and nobody knows where she is—she completely subverted the community safety plan that we had all been putting quite a lot of effort into for five weeks. We rang ACIS, the police and the hospital. Apart from the police the people who referred her to us were not there—it was after hours. They gave us a stock response, saying, ‘We’ll assess her when she comes.’ It is that same thing of ‘Here we are trying to keep her calm and not as worked up as ever’. If she somehow got into their system she would maybe appear calmer than when she was first admitted—when she had no clothes on, had harmed herself and a whole range of things that clearly meant they had to take her in. I was trying to say to them, ‘But all her community support systems have just broken down, so she is now vulnerable. It is like you have released her to nothing.’ They could not take on that piece of information. We were all left at a slight impasse. Obviously their loads are such that they needed her to be at a certain level of distress to get into the system. We have been a part of not keeping her at that heightened level of distress and now we are going to have to wait until she gets to that heightened level again, at which she might die. By that time I have had three or four workers involved in this process for five weeks and now there is a great gaping hole. That is not an uncommon story. We think it is a good story, because it had come from the hospital.

Senator MOORE—What should have happened?

Ms Ralfs—It might have been just a conversational thing whereby the front-line people could say, ‘Okay, I hear you are feeding in another risk factor. This person has been in a community support safety plan and she now does not have one.’ So it does not matter what she sits there and says; that is information they have got about her as a risk factor. They should have been able to reassure me that they were going to take that into account. What we have seen time and time again is that people get released. We have been working with them and we know about them. I understand why it happens. That is why I am trying to say that I am not blaming; I am just saying there is this changeover from community to acute that is actually quite a dangerous period and is a hole in the suicide prevention strategy, and you are trying to get the community involved.

CHAIR—This is where there has been a lot of discussion about step-up and step-down facilities.

Ms Ralfs—That is right.

CHAIR—What is the situation here?

Ms Ralfs—I am less aware of them. That was certainly never suggested to us. Maybe that is something I could take from here to find out more about. But we are certainly not using them.

Senator MOORE—The government is appearing next.

Ms Ralfs—Maybe we should just—

Senator ADAMS—It is not very known?

CHAIR—As a service provider, you do not know about it?

Ms Ralfs—No. And that would be great.

CHAIR—You are probably aware that we have been to a number of cities. It is slightly different in each state, but we are hearing repeatedly around Australia that one of the reasons they put up for not engaging too much with the service providers is privacy issues. Is that a factor? Also, is it an issue about capacity?

Ms Ralfs—I would interpret it as capacity, but I would also interpret it as a misunderstanding of the systems, which is what I wanted to use your inquiry for. I was not in any way trying to imply that our staff or our situation could give a clinical perspective on it that would trump theirs. It is just another factor. That is why I used this one particularly. They sent her to us. We worked with her and then, when we wanted to send her back, it was like all of our work was irrelevant to them. By Monday, when I got to talk to the person who referred her to us, of course they interpret it, but it is what could have happened over that weekend that was my—

CHAIR—Which would have been a dangerous period.

Ms Ralfs—Yes. So I think it is more about, as those protocols get developed, understanding that we are feeding in some information that may not look obvious. She is not necessarily going to report it either: ‘Yes, I just left everybody who was looking for me and I went and hid.’ But the police were looking for her, and they might have ended up taking her, you see. That is what I was concerned about. She was reported as a person missing and they could have ended up taking her to hospital.

Senator MOORE—I am still unsure about this paragraph, which I have read several times. It is the second paragraph on the page after the case example. It is what we have been talking about. I understand the need for respect and that the life and the work experience of community workers should be valued. I understand that really well. But I do not understand this:

> In fact, the hospital themselves, had previously come to this conclusion. By refusing to take on the information provided in preference for that obtainable through clinical assessment, they refused any responsibility for the situation …

Are you saying that the clinical assessment may not have picked up—

Ms Ralfs—Yes.

Senator MOORE—So the purely clinical assessment at the hospital may not have taken this into account if she was representing as calm and reasonable when she got there?

Ms Ralfs—Yes.

Senator MOORE—I get that. There was a kind of conflict in the paragraph.

Ms Ralfs—She is released from hospital on the understanding that she is still potentially suicidal.

Senator MOORE—But only released because she has been released into a community program.

Ms Ralfs—Because there is all of this stuff around—and then it all breaks down and then they are just going to go to some normal level of admission, normal criteria for taking her back into the system.

Senator MOORE—So, in the best case scenario, if she got back to hospital—because that would be the best case, that she got back there—

Ms Ralfs—Yes. The police were looking for her.

Senator MOORE—you do not believe, from your experience, that the hospital mental health people would have given due importance to the information provided.

Ms Ralfs—We got told categorically they would not.

Senator MOORE—You believe that is a state hospital process.

Ms Ralfs—I believe it is a misunderstanding of the community and the acute system. I think the workers that were responding to us at that time were responding out of what was totally appropriate for their work, but it took—

Senator MOORE—It defeats the whole purpose.

Ms Ralfs—It is a problem.

Senator MOORE—So that is the last paragraph in that area, which is really important. Thank you—I am sorry for doing it but I just could not get that paragraph. I tried and tried.

Ms Ralfs—I am sorry that we wrote that so obscurely.

Senator MOORE—That is just me.

Ms Ray—It is often the changes within the context and situations that the people around the person would notice far more than at the presentation at acute care.

CHAIR—They can just present without having that.

Ms Ray—There was a case where there had been domestic violence. The man was in quite a state. He had been drinking. The police were called because he did not see the point of life any more. His partner had left and he did not have access to his child at that particular time. He got to hospital, was quite suicidal and yet managed to talk himself out of that hospital as quickly as possible, and they let him go in his car as well, which blew me over. I thought: ‘My God! You’ve been drinking and all.’ He is still alive, but it was one of those moments where you also think he can also hop in his car and think, ‘That’s it. I’ve reached the bottom of the pit.’ Yet family were trying to tell the hospital: ‘Keep him in there.’ They were really surprised that he was not kept in because they had progressively seen him go downhill and become more despairing. He did not have a mental illness, but it was a contextual situation.

Senator MOORE—So what do you say to the consumer movement who say that often family and others have some kind of vested interest in presenting their case in as negative a position as possible—this is from previous inquiries. and there is no right or wrong answer to this, I assure you? But from the consumer network for people with mental health issues, they are extraordinarily concerned about any practitioner taking the words of family or other people with more relevance and certainty than their own evidence. In that awful kind of dilemma, is that something you have come across as well—the role of the person themselves saying, ‘It’s me. I’m the one who knows me best. Listen to me not to them’?

Ms Ray—Absolutely, and I want to point out that that previous situation was not mental illness and I think that makes a difference. He was someone who does not carry a diagnosis of mental illness yet his desperation gets worse and worse. With mental illness, it is a hard one. I have seen people who make a good self-call on that in terms of where they are at with their health; and at other times they are not quite making the right calls on their health because they are not well at the time and they can be unsafe and highly vulnerable.

Ms Ralfs—I think it goes back to where that protocol as the shift from community took you. They have got different orientations almost, and I think it is more work and more consciousness. I know from all of our training and all the rest of it that we are going around promoting people to be involved in these safety plans, working with people, community support. That is a whole orientation in a SQUARE document; it is part of mental health first-aid training. If they have been doing all of that but then it starts getting to the acute end of that, what is the handover between those systems? I am not expecting you to have an answer, but we are going to create disappointment and frustration—and we are doing that—by not recognising that. I am trying to draw attention to that and the step up and the step down—

CHAIR—The protocol, the sophisticated coordination and collaboration that you talked about.

Ms Ralfs—The way of taking the information even, the almost consumer oriented position that says, ‘Why would we listen to what you are saying?’ I would like to point out that the police did a fantastic job that night, and one of the reasons I think they did a fantastic job is they acted completely on face value, which really had use in that situation. They just took it as a missing person. They went and looked. When she eventually turned up, they went and checked. They just acted in their way. They were not trying to be counsellors and they were not trying to do anything. They just did their practice and it fitted in. So I think there is more work to be done in the transference for community care. Somebody needs to work out a solution. Somebody needs to experiment. I do not think we have done enough of that to come up with answers and I think you are pointing to a dilemma. We could talk about that for quite a while.

Senator WORTLEY—Do you deal with adolescents as well in Relationships Australia?

Ms Ralfs—In our Aboriginal youth worker training programs we are dealing with adolescents to some degree, but that is not our main focus.

Senator WORTLEY—It is not your main focus, so generally you do not. So there are other areas?

Ms Ralfs—Our family services are the main component, but there are other specific services.

Senator WORTLEY—Right. So through the family services you could find yourself dealing with adolescents.

Ms Ralfs—We do.

Senator WORTLEY—Is there a difference in the way you would deal with an adolescent confronting these issues, as opposed to an adult, or is it the same process?

Ms Ralfs—We would hope that we deal with everybody uniquely, to engage with them over what their issue is and work with them around what they need. So we would approach it in a similar way. The age they are would give us different legal obligations, or not, and it depends on what basis we are engaged with them. If they are part of a separated family and they are 15 or 16, that is going to put us in quite a different position than if they are, say, part of one of our education groups or our strengthening communities programs, or if they are somehow involved with workers who might also be training youth workers on the APY lands. So it depends how they are coming to us as to what our responsibilities and our response would be.

Senator WORTLEY—Can you take us through a referral to you and the time frame it takes for someone to actually access any of the services or any other support that they need? If someone is referred to you, what is the time frame? For example, does that person get to see you that day? What happens?

Ms Ralfs—From the hospital, she did. We took that straightaway.

Senator WORTLEY—Is that in working hours or outside? I am just trying to work out the access and the time frame.

Ms Ralfs—It was business hours when they rang. It was an after-hours appointment when she came, but she came from the hospital in a taxi and went back to hospital. So we did it that way. Our gambling services are pretty quick.

Ms Ray—With our gambling health services, people are contacted within 24 hours preferably, but certainly if we get a referral through from, say, the casino and someone is quite desperate it will be there and then. A worker will be available, and if by chance there are no gambling help staff a counsellor from family services will pick it up. So, if someone gets an immediate intake, there would be an assessment done of where someone is, how serious it is, whether they need to come in and whether we do a referral to ACIS as such. But it is fairly quick. Someone once rang our service out of the blue and was quite angry but also certainly quite suicidal, and that was a tricky one because there was nowhere we could point to. He was just wandering the streets, so in that instance we said: ‘Hop in a taxi. We’ll pay your taxi fare. Come into our office.’ Once it is in the office we can have a look and see what is actually happening. It is fairly quick.

Ms Ralfs—It depends where it has come from. If it has come through our family dispute resolution processes, if somebody has been in severe violence or if we think a man is escalating out of control, we are going to put services around that person straightaway. When you ring up, if it is DV or child sexual assault, we will escalate it quickly because we know that, just like with gambling, you need to act while the person is saying those things; otherwise, they will disappear.

Senator WORTLEY—When they come to you, your counsellors make an assessment. If they are assessed as acute—

Ms Ralfs—If you ring up for an appointment with a counsellor, depending on which office ring, you could wait six weeks. But if we have somehow come into contact with you, we will feel socially responsible and do something—particularly when it is an acute issue, because we do not think you should just have to wait until there is a nice appointment.

CHAIR—I want to get some further thoughts from you on the relationship with the acute sector. We touched on better collaboration and you mentioned protocols. Is there a role there for establishing a clearer set of protocols between the community sector and community service providers and the acute sector? if you work in a community service you would know what you can expect, and you know what your responsibilities are if you work in the acute sector. The person in those circumstances over the weekend knows there is a process they need to enter into. Do you think there is a need for that? Have you had any engagement with the acute sector to work on those sorts of issues?

Ms Ralfs—I know from the SQUARE project that the whole issue of referral between ACIS, the hospital, GPs and all the rest of it was a big issue—and they are all in the acute sector. So I am happy to wait for our turn. That is where some of these ideas come from for me. You need to know there is a way you can transfer from a GP to an emergency department to whatever sorts of services ACIS is offering now—they keep expanding, which is good. That needs to happen. I know that part of that work is about clarifying what the doctor means when they tick this box. There is work to go on both those ways as well. When they get information from us that we have abandoned our safety plan for a client because she is not complying, they have a way of interpreting that information. At the moment, it feels like the conversation is about trying to make that the most important thing. I think I could have settled down the workers who were involved in that if we all knew that they took the information seriously and were going to read that into whatever they were going to do with that person. It is the same for gambling. They are not going to sit there and tell you it is about gambling. They are not going to disclose the things we have been working with them on. We also have issues with the Family Court around dispute resolution, violence and all the rest of it. So things that do travel appropriately and you do not have to reveal all the details of the case—

CHAIR—You just put flags on them.

Ms Ralfs—Yes—so it means something and they see it as another factor they have to take into account and it does make a difference. It is not just professional respect I am trying to get; we feel like we have all done our job but we have left a great big gaping hole. We put five weeks of work into it and she ends up dead and we all have to deal with what that means. It is for those reasons that we want to make sure that the information travels appropriately. I know from our dispute resolution that it is the same sort of process. We do not want to leave things hotting up so that somebody does something that is irreparable. It feels like that with this.

CHAIR—When you identify suicidal ideation do you have trouble referring those people onto acute services, or is that fairly seamless?

Ms Ray—That is reasonably okay.

CHAIR—So it is more when you are part of a person’s care plan that you are having trouble with how you implement that and interact.

Ms Ralfs—‘Can we have our support back! You’ve had them, we’ve had them; could you take your business?’

CHAIR—It is a team approach.

Ms Ray—That is right. I think increasing collaboration is about the information flow. Yes, ACIS can make an assessment but there is little backwards and forwards. They might present really calmly, but we also know this, this and this has come. Also, once they have done the assessment, what is the next step back?

CHAIR—Are you aware that, in South Australia, everybody who has been in hospital has to have a care plan when they leave?

Ms Ralfs—I do not know that.

CHAIR—Some states have that and some do not.

Ms Ralfs—It is about what seemed to be happening in relation to those things.; it is about what it means.

Ms Ray—That is right: what does it mean and how does it get supported? One can walk out with a care plan, but what is the support around it to implement it?

CHAIR—Exactly. It is about whether you have got a human being there at the end.

Ms Ralfs—And they had a care plan in this case also, but that had meant they had made two calls or something, whereas we had enacted a whole community thing around it. Does that make sense?

CHAIR—Yes. That is the case study. The issue there is the two sets of care plans.

Ms Ralfs—Absolutely.

CHAIR—I see a care plan as being a real care plan.

Ms Ray—It is a case management approach.

Ms Ralfs—That is really important, and we respect that we need to work within that. But I go back to the training of the community sector: we should tell them that how they relate is quite important and about what happens when that breaks down.

CHAIR—Thank you. Your time was very much appreciated.

Proceedings suspended from 2.53 pm to 3.11 pm

HONEYMAN, Dr Margaret, Director, Mental Health Policy, and Chief Adviser in Psychiatry, Department of Health, South Australia

SHERBON, Dr Anthony Kenneth, Chief Executive, Department of Health, South Australia

CHAIR—Welcome. I understand information on parliamentary privilege and the protection of witnesses and evidence has been given to you. As departmental officers, you will not be asked to give opinions on matters of policy, although this does not preclude questions asking for explanations of policy or factual questions about when and how policies were adopted. The committee has before it your submission. Thank you. I invite either or both of you to make an opening statement, and then we will ask you some questions.

Dr Sherbon—We do not have an opening statement.

Senator MOORE—There are two things I want to cover. One is about people leaving hospital after they have had issues and the care plan arrangement. I am from Queensland, and we heard considerable evidence in Queensland about the release process and what is supposed to happen. We heard evidence from both sides about whether it happened. The other thing is to do with evidence we have just had from one of the local NGOs, who talked about extensive waiting lists in CAMHS, which I take it is the Child and Adolescent Mental Health Service, and for something else, which also had a very long waiting list. But it was just in terms of waiting lists and what happens to people who have shown incidents around suicide and concerns in that way. Those are quite general issues and I thought I would throw those on the table straightaway.

Dr Sherbon—I will ask Dr Honeyman to address the issue of post-discharge arrangements in a minute, but in terms of waiting lists I monitor monthly the waiting time for new appointments to the Child and Adolescent Mental Health Service, as well as to the adult Community Mental Health Service. The waiting time for adults is far shorter than that for children, but in all cases we prioritise the appointment based on the urgency described to our staff by the referring practitioner, whether it be a doctor or another clinician. So, if someone is urgent, then they are seen urgently. Of course, if someone expresses suicidal ideation, they are referred immediately to the emergency department, where they are assessed immediately.

Senator MOORE—What are the standards waits? If the referring person does not indicate an urgency, what is the kind of wait for a child or adolescent appointment?

Dr Sherbon—Three months. For an adult, it is two weeks.

Senator MOORE—I knew that two-week figure from somewhere. I did not know the child and adolescent one. Does that vary across the state?

Dr Sherbon—That is for the Child Adolescent and Mental Health Service at the Children, Youth and Women’s Health Service. The waiting time in southern Adelaide, which has a separate child and adolescent service, is similar.

Senator MOORE—What about regional South Australia? What does that come under?

Dr Sherbon—The state-wide service is run out of the Children, Youth and Women's Health Service.

Senator MOORE—So it does not matter where you are from—

Dr Sherbon—No, that is the waiting time—that is for non-urgent cases. As I said earlier, more urgent cases are seen more urgently, and if someone has an expressed suicidal ideation then they are usually referred by a GP or the police or their family to an emergency department.

Senator MOORE—And what was the one that you were going to tell me about?

Dr Sherbon—The post-discharge arrangements.

Senator MOORE—Thank you very much. I knew we had referred something to you, and I was sitting here going, 'What was it?' I tell you, I am losing my mind!

Dr Sherbon—Just to clarify: so you were talking about an issue where someone has attempted suicide or expressed a suicidal ideation and the assessment—

Senator MOORE—And where they are in a hospital situation; what is the process for when people are released? We have heard around the place that there are supposed to be care plans developed for anyone about whom there is an expectation that there needs to be future care—not hospital care but future care. What is the release process for people coming out of a hospital situation? How is it handled in South Australia?

Dr Honeyman—Firstly, I would like to use the term 'discharge planning' rather than 'release' which has rather correctional overtones. Discharge planning should be done in conjunction with those to whom the patient is going to be discharged for follow-up; that would be the ideal. This is not necessarily consistently done. We are in the process, as you probably know, of a major reform in terms of how our services are delivered, and part of that is ensuring that everybody who comes into the service has a designated care coordinator based in the community. That person should be identified early, even though the patient is an inpatient at the time, so that, ideally, there will be an in-reach connection to assist with discharge planning. With those sorts of arrangements happening well, pick-up after discharge from hospital would happen at a period of time that was consistent with the need of the individual patient. So it might be the next day or it might be during the ensuing week, depending on people's circumstances.

Senator MOORE—Is the discharge planned around an NGO or a community mental health service or what? So, when you leave one of the major hospitals, a care coordinator is not a family member?

Dr Honeyman—The care coordinator would be a member of the community mental health services. NGOs may well be involved in the after-care as well, and certainly we are trying to ensure that carers, whether they are family members or others, are involved in the treatment care planning as well. The care planning document was relatively recently developed but it has been rolled out, I think, to most parts of the state. It is being followed, as I said, with varying degrees of consistency, and sometimes those are systems issues rather than clinical practice issues.

Senator MOORE—The last evidence was from one of the NGOs that are involved in that process, and they described a case study which involved someone going from hospital into community and having issues, and then the relationship between the NGO and the hospital. It might be easier if you referred to the whole discussion around it in *Hansard* because you have got to see exactly what was said. But the issue seemed to be that the NGO did not feel that the hospital gave real respect to the information being provided to them from the NGO—that there did not seem to be that partnership arrangement which, I feel, is the basis of the whole thing, where each person does their bit of the job. But I will refer you to the *Hansard*. We will get it sent to you, of course, for your own evidence, but we will make sure that we highlight the evidence from Relationships Australia who came before you so that you can have a look at that and see what they said.

Dr Honeyman—Would you like me to comment on that at the moment?

Senator MOORE—If you can.

CHAIR—If you want to, that would be appreciated. But if you feel like you have not got the full picture, we would more than welcome further feedback.

Dr Honeyman—A general comment that I would make is that historically—and this is not restricted to South Australia—there has been a relatively slow development of mutual respect for people’s roles and responsibilities. Sometimes mental health services have isolated themselves a little bit both from the NGO sector and from families in terms of sharing important information. I believe that that attitude and that culture is changing, but it does take a little time for that kind of change to become really effective in terms of good communication and respect for each other’s components to care.

Senator WORTLEY—Can I ask a question in relation to that. I think that Relationships Australia said that the hospital made reference to them in the first place and that was a good relationship—the information was provided and so on. But then when then they had to hand it back to the hospital it perhaps was not as forthcoming—

Senator WORTLEY—Professional.

Dr Honeyman—Yes, professional. Obviously they thought the NGO was the relevant organisation to hand it to. Then the relationship changed when they needed to hand it back.

CHAIR—We had a bit of a discussion around their point that there needs to be more significant collaboration and maybe the development of protocols between the community sector and the acute sector so that everybody involved knows what the process is and what they can expect from the other. That built in the issue around acknowledgment of who provides what services and that there is a role being played by everybody. I am wondering: have they or anybody approached the department or the government about that and is there any move to formalise that collaboration?

Dr Sherbon—We have a formal agreement with SACOSS which describes the fundamental relationship between the government sector and the not-for-profit, non-government sector.

CHAIR—That is some sort of compact or—

Dr Sherbon—Yes. The recent name of that escapes me. It was called ‘Working Together’, but there is a recent reiteration that has just been signed. That forms the platform for our ongoing relationship with the NGOs and does describe an equal partnership in a range of government services, including mental health. The model of care that we are implementing, as Dr Honeyman alluded to in her previous answer, involves a community mental health model of care whereby each client or consumer of ours will have a key worker who will coordinate not only their clinical care but also their holistic care through non-government organisations. That is the focus point that we are building into our model of care in the community. As Dr Honeyman said, it is not fully implemented at this stage. It is part of our reform process that we are busy implementing as we speak. When we do work with NGOs for our mental health consumers, the basic policy is that we work in partnership for the betterment of the consumer. Partnerships work on a cultural understanding between two organisations. It occasionally gets frayed, particularly in the acute focus of the emergency department. But our general policy is that people should work together and acknowledge each other’s roles as equal partners.

CHAIR—So what happens in the event—and there is a case example in the submission and we talked about it just before you appeared, in fact—of a miscommunication? Is there a process where they can then pick up the phone and talk to somebody and say, ‘In this particular instance it did not work; how can we improve it?’

Dr Sherbon—In the future that will be our key worker. Each consumer will have a key worker. Currently it is the community mental health team person who is on for that day.

CHAIR—So in the future you will pick up the phone and talk to the case worker.

Dr Sherbon—The key worker.

CHAIR—The key worker, yes.

Dr Sherbon—Yes.

CHAIR—If it turns out to be a systemic problem, is there a formalised process under the ‘Working Together’ model in which the community can say, ‘This is not quite working; how do we fix it?’

Dr Sherbon—There is a system. The overall government NGO compact, if you like, is supported by a regular four-monthly meeting with me and, in particular, with heads of key NGO peak bodies. From there, issues are raised, usually of a fairly general type, but sometimes there are specific issues and we can sort through them. Either me or my delegate meets with the peak bodies every four months. That includes health, housing and disability NGOs, in conjunction with the chief executive of the Department of Families, Housing, Community Services and Indigenous Affairs. That provides an avenue for NGOs to raise issues on a systemic basis. That is prescribed in the compact. Most community mental health teams would have meetings with their own local NGO providers and we also do that at a statewide level. So there are other avenues for NGOs to raise systemic issues.

CHAIR—Relationships Australia—and it is on the record, so I am not breaking any secrets—in this case were providing community care for this particular person. Are they classed as one of your mental health community organisations? Would they come into that round of consultation and discussion process or would they be separate?

Dr Sherbon—We meet regularly with the Mental Health Coalition, which includes a range of non-government organisation members as well as consumer organisations and carers. I am not sure whether Relationships Australia is a member. I would have to take that on notice.

CHAIR—In this case they are providing community care under the care planning process. Would any organisation that is providing that sort of care—they were asked to do it by the hospital—automatically be part of that partnership approach? Is any organisation that is providing formal community care—

Dr Sherbon—Not any organisation, but those which we contract with or fund—

CHAIR—That is what I mean. They were contracted to provide this service? Sorry if I did not frame that question very well.

Dr Sherbon—Yes. We would see them as an equal partner in the ongoing care of that client. Clearly, their focus is probably more on holistic support of the consumer’s needs and our focus can sometimes be somewhat clinical. But, as Dr Honeyman outlined, our community mental health model of care is increasingly moving towards key partnerships to provide holistic support—not care; support—to mental health consumers, their families and their carers.

Senator ADAMS—Thank you for coming, Dr Sherbon. I want to ask you about your statewide suicide strategy, which you state is currently under development and will be released for broad consultation in 2010. Where are you at with the strategy and has it been released?

Dr Sherbon—As you know, the government in this state has just come out of caretaker mode. We will have before the minister a strategy later this year. Is that correct?

Dr Honeyman—That is the plan, yes.

Senator ADAMS—So later this year—when?

Dr Honeyman—I think towards the end of the year. I do not have a specific date in mind, but it certainly will be before the end of the year.

Senator ADAMS—I would just like to ask you about rural and remote issues. Is the Emergency Triage and Liaison Service up and running for rural and remote regions?

Dr Honeyman—Yes.

Senator ADAMS—How does that work? Could you give us a bit of an example of how it works and how many teams are around? Or is it done by phone?

Dr Honeyman—It is a very active telephone service that is manned 24 hours a day by senior experienced clinicians. The number is very widely known throughout rural and remote South Australia and it is a well-used service that gets good feedback.

Dr Sherbon—So the model of care is a general practitioner or a community mental health worker or, indeed—

Dr Honeyman—A general health worker.

Dr Sherbon—A general health worker, say, a nurse working in a emergency department can contact the line, and they get specialist mental health support and are linked up to the appropriate service immediately. For much of the time the service can wait until morning but, if necessary, acute interventions are assisted over the phone and, if necessary, the consumer or the patient may need to be transferred to Adelaide for inpatient care.

Senator ADAMS—Concerning the Adelaide A&Es, as far as triage is concerned, do you have someone on call or present that can deal with people who have self-harmed or are in a very agitated state?

Dr Sherbon—We provide an acute mental health service at all our emergency departments and in our larger emergency departments. In particular, in the metropolitan areas there are mental health nurses rostered in the emergency department dedicated to mental health care. They are supported by psychiatrists and junior medical staff on call.

CHAIR—So there is somebody with expertise in all emergency departments all the time in the metropolitan—

Dr Sherbon—In the larger metropolitan ones—

CHAIR—But not in regional areas—

Dr Sherbon—In the regional ones we have the support service that we just described. But clearly, in the peri-urban hospitals they tend to relate to their local larger hospitals—so Gawler hospital will relate to Lyell McEwin, and Mount Barker to Royal Adelaide, and Victor Harbor to Flinders Medical Centre—rather than use the call line, which is for more distant rural locations.

Senator ADAMS—For the Royal Flying Doctor Service, I note here that you talk about your new mental health legislation that has been passed and that you are going to:

> ... improve provisions in relation to patient transport, allowing mental health clinicians, ambulance officers, Royal Flying Doctor Service medical officers and flight nurses to transport people with a mental illness.

What have you done? Can you explain what process you have used there to improve the situation?

Dr Sherbon—In the past the situation was very heavily dependent on the police, which extracts police resources from front-line duties, if you like. So we have now built into our legislation far more flexible arrangements that Dr Honeyman will implement as part of the implementation of our new legislation.

Dr Honeyman—I think that it is a significant improvement, because the involvement of the police increased the trauma of the event for the consumer and their families. Now there is a wide range of people who are enabled to provide transport to the level that is required depending on the clinical needs or the safety issues. If there are safety issues, of course the police would still be involved, but an assessment is made of that particular need. As part of the implementation of the new legislation there have been targeted training sessions for all those other agencies that are involved and named in the act.

Senator ADAMS—Nurse practitioners is the next subject. I notice that the government has made available $1.6 million to recruit eight nurse practitioners and that at the moment you have recruited four. Have those nurse practitioners had experience with mental health or with people—

Dr Sherbon—Yes, these are advanced skill mental health nurses. These are people with substantial mental health experience and expertise. As you said, we have recruited four in the rural areas and there will be another two by the end of June this year, and eight will eventually be recruited across rural South Australia. Yes, their role is as a first-line support to a range of general health workers in rural communities and, yes, they have considerable expertise.

Senator ADAMS—In Western Australia we have what we refer to as a step-down facility. Could you give the committee an idea of the structure of your new facility at Glenside and how it is going to deal with patients?

Dr Sherbon—Glenside is changing. It is probably one of the last old-style mental health facilities.

Senator MOORE—That was the old mental health hospital in South Australia, wasn't it?

Dr Sherbon—Yes. It still is a mental health hospital, and it is evolving into more of a statewide specialist centre, so acute care is increasingly devolving to general hospitals. We have recently established an acute care unit at Flinders Medical Centre, expanded one at Queen Elizabeth Hospital and built a new one at Lyell McEwin Hospital, as well as making a number of other improvements to acute care in our general hospitals. So Glenside has changed its role. It was the be all and end all, if you like, of mental health up until recently, in that anyone with a mental health condition who required admission would be admitted to Glenside. It will now increasingly focus on highly specialised acute care that requires a high level of intervention; long-term rehabilitation, for consumers who need more extended support and clinical intervention over a longer period of time; and maternal and neonatal care. There will also be a coexistent drug and alcohol rehabilitation centre. So it will become, instead of the general point at which patients are admitted to hospital, a specialist support centre. That new construction has just commenced.

Senator ADAMS—Do you have anywhere in South Australia where someone who has been discharged with a care plan can go as an interim measure before they go home?

Dr Sherbon—Yes. In our submission we described the South Australian mental health strategy, which I probably should have addressed by way of opening statement, but I was saving you the time. Now that you have asked about that, I should explain it. Our long-term mental health strategy is called Stepping Up. It was recommended to government by the Social Inclusion Board of South Australia and endorsed by the Department of Health. It is a very substantial strategy that involves a fundamental rethink of the way we provide mental health services. Included in that strategy are a whole series of levels of care. People move into a level of care depending on what level of intervention they require. So, if they need acute care, the general hospital mental health system is there to assist, with Glenside available for support with highly specialised needs.

But, as you say, many people will require a step-down level of care, so we are building four intermediate care centres across Adelaide. These will be largely nursing-led centres of about 15 beds each, where people will stay for three weeks to three months to have their clinical condition stabilised whilst maintaining their daily living skills in a rehabilitative environment. We have also recently built three community recovery centres, which are focused more on rehabilitation, where people will be able to stay for one to six months in a much more residential type of environment. That is the next level of care down. The level of care below that is supported accommodation. With the assistance of the federal government, we are now providing a substantial increase in supported accommodation across not only metropolitan but also rural South Australia. In supported accommodation, the consumer is, obviously, housed but also receives support for their daily needs, whether they be in employment, housing, law or other areas. That five-level strategy is the key document that we work to in mental health.

Senator ADAMS—Regarding the APY Lands, when problems are faced by the Indigenous communities, what services do you have to back that up?

Dr Sherbon—Services to the APY Lands have improved in recent years. I think it is fair to say that state government services to the APY Lands have been inconsistent in the past. We now provide particularly child and adolescent mental health support to the Lands. The Nganampa Health Service, which oversees the Aboriginal Community Controlled Health Organisation in the Lands, has received federal government money to provide fly-in, fly-out adult psychiatry and also two mental health nurses who are based on the Lands. We support those workers in Nganampa Health as they require assistance from us. Also, as I said, we provide child and adolescent mental health services on a fly-in, fly-out basis, and of course we provide support to the GPs as required. There are two GPs working on the Lands in Nganampa Health. I have asked Nganampa Health to join with us in a more comprehensive strategy for mental health on the Lands. There is a lot of unmet need on the Lands and we should work with the Commonwealth and Nganampa Health to meet those needs. We are in the early stages of planning a much more comprehensive strategy for mental health on the Lands.

Senator WORTLEY—This morning we heard from a number of witnesses who raised the issue of accurate reporting of deaths by suicide. I refer you to the submissions by the South Australian State Coroner, Mr Mark Johns, and Associate Professor James Harrison from Flinders University. The evidence provided was that the figures are somewhat higher than they are able to provide to us. In relation to the state department, what plans are in place to address the issue of accurate data in relation to mental health, and particularly in relation to suicide, in South Australia? What are the consequences of not having accurate data available?

Dr Honeyman—There are several issues—that a cause of death may be recorded as an overdose or as death by asphyxiation or hanging but not recorded as a suicide. Better management is outside our control to a large extent. We meet regularly with the coroner to discuss these issues. I believe that there are some concerns about the impact on families or the community if deaths are recorded as suicide, but at the same time it does lead to, as you have pointed out, a degree of underreporting. There are also issues around the data collection and whether the individual was of Aboriginal origin or not, because the demographic forms may not record that information or they may not know. That is another area of inaccuracy. The concern about the figures for me is that, if we are underreporting then we are not acknowledging the true extent of the issue and therefore the measures that we need to take to address that.

Senator WORTLEY—That is specifically why I was raising the issue. I note that the coroner in his submission says that the Coroners Act as it now stands prevents a finding of suicidal intent without an inquest.

Dr Sherbon—That is a matter for the Attorney-General in South Australia. From the health department’s perspective, we would encourage any alteration of procedure or policy change on behalf of the Attorney-General’s Department that would improve the accuracy of reporting of suicide in South Australia. The coroner and our department are increasingly seeking to revise deaths that are unexplained and to ensure that as many as possible of those that are evident suicide over a period of time are duly recorded.

Senator WORTLEY—I note also that in the coroner’s submission he mentions that funding to continue the research work was not made available and the opportunity to analyse the wealth of coronial narrative data had not been pursued by the Department of Health.

Dr Sherbon—Which year, Senator? I do not have his submission.

Senator WORTLEY—This was 2007-08. The information was taken from the annual report and it was following some research that was being done within his office in relation to suicide.

Dr Honeyman—Yes, it was, and that particular piece of work was completed and written up and I think parts of it are being sent for publication. The research could have continued but in the view of some the additional information that was going to be collected by continuing was not going to add further value because the findings were obvious in terms of, first, the underreporting and, second, some of the critical factors which had been identified as precursors of suicide or attempted suicide which were perhaps not adequately recognised either by the community or by the health workers that people might have consulted. So there were some really worthwhile genuine findings but it was not clear how continuing research would add to what had already been established. I guess that developing the pathways, if you like, for care seemed to be the next step.

Senator WORTLEY—One of the other issues that has been raised is that the number of suicides recorded in South Australia is greater than the number of road deaths annually and yet the latter is something that is in the media often and a lot of attention is paid to. There was a suggestion that that attention is not being paid to the issue of suicide because it is not something that is spoken about in a much broader sense within our community and that we need to address the issue of suicide as being something that is delivered through programs to our communities. I understand that the organisation MindMatters, which presents in a number of schools in Australia, is one of those organisations that is involved in addressing that issue, so they are talking about within schools there. But within the more general community it is not something that is spoken about. In fact, in many instances it is something that is hushed or spoken in a very quiet voice because it is not something that people really want to know about. As has been suggested, would there be a benefit in it not being put up like the road tolls but being out there more so that people were actually aware that it is an issue that needs to be addressed?

Dr Sherbon—It is an issue that the health department takes very seriously and in no way is it put to one side by the health department on account of any community concern about appearances. There were 202 suicide deaths in South Australia in 2007, which is the latest figure I have in front of me, and that is higher than the road toll, so you are correct.

Senator MOORE—Two hundred and two that we know of.

Dr Sherbon—As reported in the report on government services. So, yes, you are correct. We have a statewide suicide prevention strategy in evolution, as Dr Honeyman said, but we have also targeted key risk points. MindMatters is supported by our mental health program in the schools. For young people we also run mental health first aid programs to help communities deal with people who may not necessarily be in contact with the mental health system, or even a GP, but who are becoming eminently at risk to themselves. We also have been very careful to ensure that supports are provided in our state drought assistance strategy to rural communities experiencing economic and other stresses through drought. That involves a very substantial mental health support to those communities. So I would like to reassure you that, although there might be some community concern about openness on suicide, it is not reflected in the Department of Health’s focus on the issue.

Senator WORTLEY—Thank you for that. My last question was specifically to Dr Honeyman. When I said those figures should be out there, I was talking specifically about the media perception and the way they are being put to the public. I understand where the media are coming from in relation of this, but I am concerned that having this discussion through the media could lead to copycat situations. That is not something that was put out there.

Dr Sherbon—In the immediate hours or days following a suicide or a near suicide episode, whilst we cannot influence the media beyond persuading them, we do ask them to report the matter in a way that ensures they focus on the supports available for the community. I have to say that the Adelaide media have been very supportive. Whenever they run a mental health story, they always provide support line information at the end. That is a very positive contribution from Adelaide media of all sorts. But, yes, we do ask that the families’ sensitivities and the potential for copycat behaviour, particularly in young people, is carefully managed by the media. I have been in this town for 3½ years and I have generally found the media to be very sensitive and careful.

Senator WORTLEY—The Australian journalists code of ethics is held in high regard.

CHAIR—I want to touch on an issue that was raised in the coroner’s report, and that is the issue of how intent is reported when there is an inquest or when there is a finding. As I understand it, Mr Johns said that, under the South Australian Coroners Act, you can really only investigate intent as part of an inquest and not just as a finding. Besides all of the other things, that is one of the reasons why suicide cannot be reported. They cannot investigate or do not look at intent under a finding and therefore do not get that information. Has changing the act to enable that to occur been considered? It seems to me that that would be an easier way of addressing some of the issues around underreporting.

Dr Sherbon—We are probably not well qualified to answer your question. The Coroners Act in South Australia is committed to the Attorney-General. Whilst we do obviously have a fundamental ongoing daily relationship with the coroner—

CHAIR—And that is the point of my question.

Dr Sherbon—we do not oversee coronial legal policy.

CHAIR—I am trying not to overstep the boundary, but have you raised that matter with the Attorney-General's Department to see if that could be fixed?

Dr Sherbon—Not in my time here, though it may well have been raised earlier. We and the coroner are always working together to improve the accuracy of the data on his findings—not the accuracy of his individual findings, of course, but the accuracy of the data provided in collective form to the public. I have not conferred with the Chief Executive of the Attorney-General's Department. You would have to ask him whether or not the Attorney is currently considering that matter, as it is a matter not committed to the Department of Health. We are health experts, not coronial law experts, so it is a matter for the Attorney.

Senator MOORE—Could you have a look at the evidence provided by the Kentish regional clinic, who run the CORES program. In their evidence they said they felt there could be an element of political activity in decisions about what fitted the current funding models and what did not. We pursued that, and the evidence we got was that the model they use, which empowers communities rather than NGOs or professionals, did not seem to fit the current way that funding is allocated at both the state and federal level. The evidence went on to say that because the people who were strong advocates for the way they were working, in your state and in others, tended to be from opposition rather than government, there was a view that they did not have the political clout to get their kind of program funded anyway.

Dr Sherbon—I can assure the committee that advice from the Department of Health is based on objective clinical evidence in relation to all suicide prevention programs. We run a program with similar objectives to those of CORES. It is called 'SQUARE', which means 'suicide questions, answers and resources'.

Senator MOORE—That is the Relationships Australia one they talked about.

Dr Sherbon—Yes. So our advice to our minister with regard to CORES is that we already fulfil a similar objective through square. The square program does provide a lot of those interventions that CORES claims to provide. Where we already have an established and functioning program that has already obtained the support of the federal government and General Practice SA it is almost a case of 'if it ain't broke don't fix it'. Why replace a program with another one when the program you have got is going well? So our advice has been that

CORES is a good idea, it is good intervention, but the square intervention we are already funding—

Senator MOORE—Fulfils the same need.

Dr Sherbon—Fulfils the same need.

Senator MOORE—I just thought it was important that that be put on the record.

CHAIR—Thank you, Senator Moore, I think you are right. Thank you, Dr Sherbon and Dr Honeyman. Your evidence and time are very much appreciated.

Committee adjourned at 3.58 pm