PARLIAMENT OF NEW SOUTH WALES

Committee on Children and Young People

REVIEW OF THE CHILD DEATH REVIEW TEAM REPORT: SUICIDE AND RISK-TAKING DEATHS OF CHILDREN AND YOUNG PEOPLE

Transcript of Proceedings, Written Responses to Questions and Minutes

Report No. 5/53 – June 2005

New South Wales Parliamentary Library cataloguing-in-publication data:

New South Wales. Parliament. Legislative Assembly. Committee on Children and Young People.
Review of the Child Death Review Team report "Suicide and risk-taking deaths of children and young people" : transcript of proceedings, written responses to questions and minutes / Parliament of New South Wales, Committee on Children and Young People. [Sydney, N.S.W.] : The Committee, 2005. 71 p. ; 30 cm. (Report ; no. 5/53, June 2005)

Chair: Barbara Perry.
"June 2005".
ISBN 1921012072

1. New South Wales. Child Death Review Team. Suicide and risk-taking deaths of children and young people.
2. Youth—Suicidal behavior—New South Wales.
3. Children—Suicidal behavior—New South Wales.
4. Risk-taking (Psychology) —New South Wales.
I. Title
II. Perry, Barbara.
III. Series: New South Wales. Parliament. Legislative Assembly. Committee on Children and Young People. Report ; no. 53/5

362.28 (DDC22)

Table of Contents

Membership & Staff

Chairman	Mrs Barbara Perry MP, Member for Auburn
Members	The Hon Jan Burnswoods MLC (Vice-Chairman)
	The Hon Tony Catanzariti MLC
	The Hon Kayee Griffin MLC
	The Hon Sylvia Hale MLC
	The Hon Melinda Pavey MLC
	Mr John Bartlett MP, Member for Port Stephens
	Mr Barry Collier MP, Member for Miranda
	Mr Stephen Cansdell MP, Member for Clarence
	Mrs Judy Hopwood MP, Member for Hornsby
	Ms Virginia Judge MP, Member for Strathfield
Staff	Helen Minnican, Committee Manager
	Pru Sheaves, Senior Committee Officer
	Hilary Parker, Committee Officer
	Kylie Rudd, Assistant Committee Officer
Contact Details	Committee on Children and Young People Legislative Assembly Parliament House Macquarie Street Sydney NSW 2000
Telephone	02 9230 2737
Facsimile	02 9230 3052
E-mail	childrenscommittee@parliament.nsw.gov.au
URL	www.parliament.nsw.gov.au

Functions of the Committee

The Committee on Children and Young People is constituted under Part 6 of the *Commission for Children and Young People Act 1998*. The functions of the Committee under the Commission for Children and Young People Act are set out in s.28 of the Act as follows:

(1) The Parliamentary Joint Committee has the following functions under this Act:

(a) to monitor and review the exercise by the Commission of its functions,

(b) to report to both Houses of Parliament, with such comments as it thinks fit, on any matter appertaining to the Commission or connected with the exercise of its functions to which, in the opinion of the Joint Committee, the attention of Parliament should be directed,

(c) to examine each annual or other report of the Commission and report to both Houses of Parliament on any matter appearing in, or arising out of, any such report,

(d) to examine trends and changes in services and issues affecting children, and report to both Houses of Parliament any changes that the Joint Committee thinks desirable to the functions and procedures of the Commission,

(e) to inquire into any question in connection with the Committee's functions which is referred to it by both Houses of Parliament, and report to both Houses on that question.

(2) Nothing in this Part authorises the Parliamentary Joint Committee to investigate a matter relating to particular conduct.

(3) The Commission may, as soon as practicable after a report of the Parliamentary Joint Committee has been tabled in a House of Parliament, make and furnish to the Presiding Officer of that House a report in response to the report of the Committee. Section 26 applies to such a report.

(4) A reference in this section to the Commission includes a reference to the Child Death Review Team.

Chairman's Foreword

The report of the Child Death Review Team, *Suicide and risk-taking deaths of children and people*, documents a study of all deaths of children and young people aged under 18 in New South Wales by suicide or risk-taking between January 1996 and December 2000 to find out what can be done to prevent further deaths. The report examines the factors associated with and circumstances surrounding these deaths, including the level of contact with human service agencies.

The death of a child or young person by either suicide or risk-taking is a tragedy which has a lasting impact on family, friends and community. The findings of the Child Death Review Team Report provide a basis for fine-tuning policies, practical programs and service provision to minimise the likelihood of young people feeling driven to take such desperate measures.

Ms Gillian Calvert, Commissioner for Children and Young People and Convenor of the Child Death Review Team, and Professor Beverley Raphael, Director, New South Wales Centre for Mental Health, provided valuable evidence to the Committee on the status of the Report's findings and the measures to improve prevention and intervention that have been taken by a number of agencies.

The need remains to continue working towards preventing family dysfunction and to raise community and professional awareness of how to recognise and respond to mental health problems in our children and young people.

I would like to express the Committee's appreciation of the work of the Child Death Review Team, and also thank Ms Calvert and Professor Raphael for their evidence and participation in the inquiry.

Barbara Perry MP
Chair

Chapter One - Questions on Notice for hearing held 23/11/2004

with the NSW Commissioner for Children and Young People on the review of the Child Death Review Team report: *Suicide and Risk-Taking Deaths of Children and Young People*

1. The Child Death Review Team's report identifies the quality and extent of information contained in records as highly variable and that while coronial files contained detailed information about the death in a case and precipitating circumstances, information about life circumstances was recorded less consistently (p.23). What are the implications of this limitation for the study and its findings and what measures could be taken towards minimising the impact of this problem in future studies?

   In particular, is this problem addressed by Strategy 5.1 of the *NSW Suicide Prevention Strategy* [Establish suicide surveillance systems for NSW], which provides for detailed profiling of suicide and suicidal behaviours, including information on suicidal ideation, suicidal behaviour and risk factors?

2. The report notes that certain legislative and policy changes have occurred since the period in which the deaths of the children and young people under examination had occurred (pp xi-xii). The *NSW Interagency Guidelines for Child Protection Intervention* also have been revised.

   (a) What effect have these changes had on child protection practice and service provision since their introduction?
   (b) Overall, have they been effective in helping to reduce the incidence of suicide and risk-taking among children and young people?

3. The report indicates that certain of the findings of the Child Death Review Team (CDRT) study were adequately recognised in the *NSW Suicide Prevention Strategy*. However, this was not the case in relation to a number of study findings. The report indicates that the Child Death Review team would allow a period of 12 months from publication (January 2003), for the *NSW Suicide Prevention Strategy* to be reviewed and updated to reflect the study findings. The CDRT 2003 Annual Report notes that the Government has not explained whether or how the revised strategy has taken account of the report findings (*CDRT 2003 Annual Report* p 91).

   (a) What are the implications of this lack of recognition and to what extent has the Child Death Review Team liaised with NSW Health and the Centre for Mental Health on the effectiveness of the Strategy and other relevant health related initiatives?
   (b) In particular, the CDRT indicated that it would await the evaluation of the projects associated with Strategy 1.2 of the *NSW Suicide Prevention Strategy* (i.e. the Families Program), which includes several programs such as the *Families First* initiative and the *Family Help Kit*. Have the evaluation

of these initiatives been completed and, if so, what is the view of the CDRT on the outcomes?

(c) The CDRT found that there is a need for the *NSW Suicide Prevention Strategy* to address the issue of the association between HSC stress and suicide, and for an urgent investigation into ways in which to support young people undertaking the HSC. In its 2003 Annual Report, the CDRT notes its concern that the finding of Higher School Certificate-related stress is not fully addressed (*CDRT 2003 Annual Report* p 91). Does the CDRT plan to approach the Centre for Mental Health directly on this issue?

(d) Have the related strategies identified in the report e.g. drug education, road safety and crime prevention been linked to the *NSW Suicide Prevention Strategy* and, if so, to what effect?

Mental health problems and distressed emotional state

4. In terms of human service agency contact with children and young people falling in the subgroup experiencing mental health problems and distressed emotional states, the report highlights several areas of inadequate practice centred on:

   - Inappropriate agency actions;
   - Failure to recognise suicide risk; and
   - Ineffective case management (p71)

   (a) Has the CDRT monitored these identified inadequacies and, if so, what did the CDRT find?

   (b) What was the response of NSW Health to this aspect of the report?

5. In the case of young people within this subgroup who had not received any mental health services, the report states that the cases "highlight the need for innovative methods to engage young people experiencing difficulties in counselling or to support them to seek some other form of assistance". Could you please expand on the nature of the innovative methods contemplated in the report?

Family dysfunction

6. The report indicates that opportunities had existed for intervention early in the lives of children and young people in this sub-group but were often lost due to inadequate risk assessment and deficiencies in protective casework. What was the Department of Community Service's (DOCS) response to this finding and what measures/initiatives could be taken to improve risk assessment and protective casework by DOCS, especially with those children and young people who came to DOCS' attention when they were already in extremely high-risk lifestyles (pp73-74)?

7. Has the CDRT been advised of the outcomes of evaluations conducted into:

   (a) the *School-Link* program and other school-based initiatives such as *MindMatters*; and

   (b) the development of an Aboriginal and Torres Strait Islander suicide prevention program and related culturally appropriate programs;

   (c) Strategy 2.1.4 of the *NSW Suicide Prevention Strategy* [Enhance local youth mental health and related services];

(d) Strategy 3.2.1 of the *NSW Suicide Prevention Strategy* [Improve education and training of primary heath care workers and general practitioners]; and

(e) Guidelines for Australian media professionals under Strategy 4.3 of the *NSW Suicide Prevention Strategy* [enhance local community capacity to prevent and respond to increases in suicide]?

If so, what is the CDRT's view on the outcomes?

8. Has the Drugs Programs Bureau completed its audit of methadone takeaway prescriptions in NSW and, if so, what is the CDRT's response to the audit results?

9. Is the CDRT aware of improved standards of service provision by DOCS and other human service agencies in relation to children and young people?

10. The CDRT found that the study suggests that education about mental health issues is not sufficient and that the *NSW Suicide Prevention Strategy* should be broadened to engage the wider community in developing the emotional literacy of children and young people so that they can obtain help on any issue when it is required. (p.113) How did the CDRT envisage that the broadening of the Strategy could be achieved?

11. The CDRT concludes that the lack of involvement of some families with human service agencies highlights "the need for innovative techniques to encourage children, young people and their families to engage in help-seeking behaviour and for services to outreach to children and young people" (p.78). What sort of techniques and initiatives were contemplated by the CDRT in this finding?

12. What further steps does the CDRT regard as priorities and what other research areas are currently under examination by the CDRT?

Chapter Two - Transcript of Proceedings (23/11/04)

REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

REVIEW OF REPORT OF THE CHILD DEATH REVIEW TEAM SUICIDE AND RISK-TAKING DEATHS OF CHILDREN AND YOUNG PEOPLE

At Sydney on 23 November 2004

The Committee met at 3.45 p.m.

PRESENT

Ms B. M. A. Perry (Chair)

Legislative Council	**Legislative Assembly**
The Hon. J. C. Burnswoods	Mr J. R. Bartlett
The Hon. A. Catanzariti	Ms S. R. Cansdell
The Hon. K. F. Griffin	Mr B. J. Collier
Ms S. P. Hale	Mrs J. Hopwood
The Hon. M. J. Pavey	Ms D. V. Judge

GILLIAN ELIZABETH CALVERT, Commissioner, Commission for Children and Young People, Level 2, 402 Elizabeth Street, Surry Hills, affirmed and examined:

Mr STEVE CANSDELL: The report of the Child Death Review Team [CDRT] identifies that the quality and extent of information contained in records is highly variable and that while coronial inquiries contain detailed information about the death in the case of precipitating circumstances, information about life circumstances is recorded less consistently. What are the implications of this limitation for the study and its findings? What measures could be taken to minimise the impact of this problem in future studies?

Ms CALVERT: The limitation that you are referring to is, in fact, a limitation in the research methodology that we have used, which was primarily to look at records. So we were therefore dependent upon the information that was available for the record, and for some of these kids there was very little information on the records about them, so we were unable to get it. We sought to address that research problem by going to every available data source that we could. Regardless of that, in tracking down every record that has ever been held on them that the CDRT were entitled to at the time, about 42 per cent of children and young people had no record of prior contact with human service agencies and the only information we could access was on their coronial file.

We have already taken measures to address that. The Child Protection Legislation Amendment Act in 2003 broadened the range of departments and agencies that the CDRT can require information of. So we now can require information of private practitioners and non-government agencies as well as government agencies. I think that has probably improved our access to records. But unless the child has a record we are unable to really take any measures to overcome it.

Mr STEVE CANSDELL: Basically, have any recommendations come out of this report that would lead to more awareness programs for parents to recognise signs?

Ms CALVERT: Of suicide?

Mr STEVE CANSDELL: Yes, depression and suicide.

Ms CALVERT: Certainly one of the findings that we had out of the suicide and risk taking report was that many of the children had told someone else that they were intending to harm themselves and, perhaps because of a promise not to tell, those people felt that they could not go and tell someone else. So we think it is important that the message is given that people break the promise to keep it quiet if they are told that someone is thinking about harming themselves; it is the one time it is okay to break a promise.

The second thing we wonder is whether there is a belief that if someone says they are going to kill themselves that they will not do it. Again, this research highlights that that is not the case and that that is a myth. So there needs to be some work done in tackling that myth about suicide and people telling.

Mrs JUDY HOPWOOD: I have a particular concern about the fact that young people do not seem to know that it is recommended that they do tell somebody else, just from my own daughter's circle of friends and the problems that they have in terms of if they find out or the

friend said something to them that indicates a potential for suicide. How do you imagine we are going to get that message out there, because some kids do not even like their school counsellor and they might be a bit guarded about telling their own parents for fear of the parents telling the set of parents involved. I think this is a huge thing. I said to my daughter, "If you cannot tell me, find an adult you trust and tell somebody else". But that is not widely known. The kids still feel the need to be that good friend and keep that confidence, and then a tragedy could occur.

Mr STEVE CANSDELL: And they live with guilt.

Ms CALVERT: I think the impact on the kids who have been told is awful. Certainly, because it is one of our findings, we thought that it was important that the suicide strategy be updated to reflect that. So we have referred that finding to the Government to include in their updated strategy. I would envisage that that is where services like Kids Help Line become particularly important, because they are anonymous services and you can ring up or e-mail and get a response from somebody who knows how to deal with and respond to those sorts of issues. Most kids are aware of Kids Help Line, they have got something like 98 per cent recognition. Having said that, that does not mean the kids will use them for that particular issue if they are worried about breaking a promise, so we felt it was important that the message was not only this is where you can go for help but that it is okay to break this promise.

Ms VIRGINIA JUDGE: I have two daughters, one is 19 and the other one is just about to turn 18, and both of them were told by a peer at school that one of the students in their year was harming herself and that another student was thinking of committing suicide. One of my daughters found this out when she was on their school excursion. In both these situations my daughters asked the student to go and see the school counsellor and they did not want to. The way my daughters found out was through a school excursion. This is a bit unrelated but in a way it is very related too because school excursions are often opportunities for students to get together and to spend more time together in an informal way. You often find that a lot of problems—whether it is about sexual abuse in the family—come out when the students are on these little camps. Even if they are going for two or three days I think the role that these camps play in schools is really important and ought to be supported. The children do feel that they are breaking the trust of that person. There was another case to do with the person's sexual identity where they found that they were a bit ambivalent about it. The school has a lot of resources so it touches every walk of life, but I think it is a really important issue.

The other issue was No. 4, mental health problems. In terms of human service agency contact with children and young people falling into the subgroup, experiencing mental health problems and distressed emotional states, the report highlights several areas of inadequate practice centred on (1) inappropriate agency actions, (2) failure to recognise suicide risk, and (3) ineffective case management. Has the CDRT monitored these identified inadequacies and, if so, what did the CDRT find, and what was the response of NSW Health to this aspect of the report?

Ms CALVERT: Certainly in relation to the first, we monitor recommendations, we do not monitor findings. So we really only had one recommendation out of this report, which is that the Government update its New South Wales Suicide Prevention Strategy, taking into account

the findings. And we recommended that those issues that you have just mentioned be addressed as part of that review and updating of the New South Wales Suicide Prevention Strategy.

In relation to NSW Health's response to this aspect of the report, they reported that they have developed Statewide training for all staff on documenting casework and assessing issues such as suicide risk; they have also developed policy and risk assessment guidelines for NSW Health staff and staff in private hospitals and they are also developing a training module to assist workers assess and work with young people at risk of suicide—and that will be aimed at both workers in government and non-government services. That is what NSW Health has advised me.

Mrs JUDY HOPWOOD: In the case of young people within this subgroup who had not received any mental health services, the report states that the cases highlight the need for innovative methods to engage young people experiencing difficulties in counselling or to support them to seek some other form of assistance. Could you please expand on the nature of the innovative methods contemplated in the report?

Ms CALVERT: I guess one of the reasons we suggested innovative approaches is because we are not sure what works. What might be required in this area is for experts to conduct further research into what approaches are effective and then to pilot them and evaluate them. Having said that, we would anticipate that they would do some of the things that you mentioned, Virginia, one of which is to provide soft entry points that kids are unlikely to go to services off their own bat, so it is through doing other activities and forming relationships with the people running those activities that kids will then start to talk about some of the issues that are in their lives.

So one of the things that we would expect an innovative service to do would be to make themselves accessible through soft entry approaches. I also think that young people often do not have access to be able to get to services, so that is where innovative things such as e-counselling and telephone counselling come into play and are quite useful and worthwhile exploring. I also think that flexible services is something that is really critical for young people and you would expect to see in an innovative approach; flexible in terms of the opening hours, so it is not 9 to 5, because kids are at school from 9 to 3. So you would want to think about flexibility in terms of your opening hours after work hours—weekends and so on.

I think, again, that is where Internet-based services also come into their own because they are 24 hours and telephone counselling services are 24-hour as well. For example, a recent innovative approach, which I thought started to demonstrate some of the things that we talked about in our report, was Reach Out's recent trial of an SMS support service for young people undertaking their HSC. You could register for this service and they would then SMS you support messages throughout the HSC period. It is an example of thinking outside the square and being a bit innovative, perhaps being able to reach out to kids who might otherwise have not had access to that.

The Hon. TONY CATANZARITI: Some of these kids will not talk to anyone about their problems, yet they are obviously having a problem. What assistance can you give to someone? How do you identify that they have a problem if they are not going to speak up?

Ms CALVERT: It is very difficult. I refer to our learning from the inquiry in children who have no-one to turn to and other research; it becomes important to surround kids with a set of strong connections to other people. That means trying to have relationships with kids in family, friendship, school, child-care and activity settings.

T**he Hon. TONY CATANZARITI:** Do the kids themselves talk about it? To try to help someone with a problem, do other kids identify their mate's problems?

Ms CALVERT: Often kids will identify a problem, and they try to sort it out between themselves. If they cannot, they will turn to some adult who will help them. Maybe that question could be directed to Professor Raphael. I am sure that the Department of Health and the Department of Education and Training have a number of programs that are aimed at skilling-up the emotional capacity of children and young people.

CHAIR: Professor Raphael is addressing the Committee on Thursday.

Mr STEVE CANSDELL: Gillian, it's all right saying that kids can seek help, but there is a disparity between country and city. On the North Coast we have half the State's mental health problems. The under-12s are normally looked after by the area health service or DOCS. After that it becomes a high-risk area and there are limited resources for them. The mental health counsellors are there for only the extreme diagnosed cases, because they do not have resources to go further. So, where do children get help? Is the Kids Help Line a 1300 number?

Ms CALVERT: Yes, it is. It is a free call.

Mr STEVE CANSDELL: Perhaps that should be advertised more widely, because basically the Help Line is their only lifeline.

Ms CALVERT: As I said, the research done into the Kids Help Line showed that it has about 98 per cent recognition, and I back up that finding. When I speak with kids and ask them who do they have to turn to apart from mum, dad and the teacher, they say "Kids Help Line", and they can recite the number by heart; it is on their bus passes, so they get constant messages about it. It does have quite high recognition. Questions on services and access to services should be addressed to Professor Raphael when she appears before the Committee.

The Hon. MELINDA PAVEY: It is 4 o'clock, and we are coming back on Thursday, so I am happy to postpone my questions until then.

CHAIR: If your questions are to Professor Raphael that is okay. Gillian will not be here on Thursday, her evidence will finish today.

The Hon. MELINDA PAVEY: My question may be better posed to Professor Raphael, but as Gillian is here I will ask her. What research on suicide by young people has been done into incidences of ADHD, drugs, Ritalin, and those particular issues. Recently there was a high profile death involving a young girl who had taken anti-depressants. Do you have any statistics?

CHAIR: Are you able to readily answer that question, or would it be better addressed to Professor Raphael on Thursday?

Ms CALVERT: It is probably a question that Professor Raphael should answer. Certainly in the CDRT 2003 annual report we found that four of the six young people experiencing depression were prescribed a particular medication. That class of anti-depressant drug, called selective serotonin re-uptake inhibitors, Zoloft, Prozac and Arapax, have been associated with increased risk of suicide in children and young people. The Therapeutic Goods Administration is currently reviewing the use of anti-depressant drugs in children and young people. The CDRT has decided to await the outcome of that review before commenting any further.

The Hon. TONY CATANZARITI: Where do they get those drugs?

Ms CALVERT: They are prescribed medications, that is why it would be better to ask Professor Raphael because she will understand the details.

The Hon. MELINDA PAVEY: The Child Death Review Team report notes that DOCS is conducting a literature review and redesigning its data capabilities in relation to child deaths. Have both projects been completed? Will the CDRT encourage DOCS centre for parenting and research to undertake research along the lines of its recommendation?

Ms CALVERT: I am not aware that the research has been completed as yet by DOCS.

Mr JOHN BARTLETT: In Port Stephens 80 per cent of call outs and other areas are domestic violence related. Obviously the effect on children is enormous. Have you looked at documentation by Triple-P in Queensland? Is there any agency in New South Wales that does anything like Triple-P?

Ms CALVERT: Yes, I am aware of Triple-P, it is a parenting program, one of the few evaluated programs on parenting education. Again, you might want to take that up with Professor Raphael. My understanding is that NSW Health has been training people as Triple-P presenters.

Mr STEVE CANSDELL: You have talked about a report on bullying and its connection with suicide and threats of suicide. Recently a son of one of my constituents has been bullied consistently. Do school principles have a role to play in lessening the impact of bullying, and possibly in mediating with young people?

Ms CALVERT: My understanding from the literature is that the most effective anti-bullying programs involve the whole school—the principle, the teachers, the students and the parents in the school community. The first step is to understand it, to commit to remedying the bullying problem. I would be happy to provide the Committee with further information on the research into effective response to bullying.

Mr STEVE CANSDELL: I would appreciate that, thank you.

The Hon. MELINDA PAVEY: Are the questions on notice not yet asked to be answered?

CHAIR: I will ask Gillian to table any further information she has, including any prepared answers.

The Hon. MELINDA PAVEY: Question three asked about the CDRT study, whether its findings were adequately recognised the New South Wales Suicide Prevention Strategy. There were issues about findings and whether they had been undertaken.

CHAIR: The answers may be tabled. The Committee would appreciate you tabling any answers you have in relation to the questions on notice for both suicide and fatal assaults, not necessarily today. The Committee thanks you for your attendance for the past two hours.

(The witness withdrew)

(The Committee adjourned at 4.09 p.m.)

Chapter Three - Written responses to questions on notice for hearing 23/11/2004

2. **The report notes that certain legislative and policy changes have occurred since the period in which the deaths of the children and young people under examination had occurred (pp xi-xii). The *NSW Interagency Guidelines for Child Protection Intervention* also have been revised.**

    (a) What effect have these changes had on child protection practice and service provision since their introduction?

    (b) Overall, have they been effective in helping to reduce the incidence of suicide and risk-taking among children and young people?

    In relation to Part (a), there has not been a formal review or evaluation of practice changes, so it is not possible to quantify any effects of the legislation and policy changes.

    The new reporting requirements and extension of mandatory reporting appears to have increased the number of reports received by the Department of Community Services by 72% in the three years to 2003. I understand this trend is continuing.

    The Office of the Children's Guardian is starting to have a positive effect on the operations of the out of home care system.

    The $1.2 billion Department of Community Services enhancement package is only now being implemented at service delivery level, so it is too soon to measure its effects, but the directions of the package are positive.

    The Child Protection Senior Officers Group has been established to drive and monitor the impact of these changes on the system.

    In relation to Part (b) of the question it is too soon to tell if they have reduced the rate of a comparatively rare event like suicide or risk-taking deaths. It will take several years at least to measure whether there has been a significant change in death rates.

    Even if the death rates fall, it would not be possible to conclusively attribute the decrease, or even part of the decrease, to legislation or policy changes. It may be more helpful to think of such changes as part of a continuous improvement process in the child protection system.

3. **The report indicates that certain of the findings of the Child Death Review Team (CDRT) study were adequately recognised in the *NSW Suicide Prevention Strategy*. However, this was not the case in relation to a number of study findings. The report indicates that the Child Death Review team would allow a period of 12 months from publication (January 2003), for the *NSW Suicide Prevention Strategy* to be reviewed and updated to reflect the study findings. The CDRT 2003 Annual Report notes that the Government has not explained**

whether or how the revised strategy has taken account of the report findings (*CDRT 2003 Annual Report* p 91).

(a) What are the implications of this lack of recognition and to what extent has the Child Death Review Team liased with NSW Health and the Centre for Mental Health on the effectiveness of the Strategy and other relevant health related initiatives?

NSW Health advise that they are currently reviewing the NSW Suicide Prevention Strategy. They have not yet reissued it.

A Whole of Government Suicide Prevention Forum in October 2003 identified priorities for incorporation into the revised Strategy. A NSW Suicide Prevention Steering Committee has been established to continue this work.

NSW Health may be able to provide further details about incorporating the Child Death Review Team recommendations into the revised Strategy.

(b) In particular, the CDRT indicated that it would await the evaluation of the projects associated with Strategy 1.2 of the *NSW Suicide Prevention Strategy* (i.e. the Families Program), which includes several programs such as the *Families First* initiative and the *Family Help Kit*. Have the evaluation of these initiatives been completed and, if so, what is the view of the CDRT on the outcomes?

As the new strategy has not been released, I am unaware of whether these remaining issues will be included in it.

The issue of the Child Death Review Team's outstanding issues in the suicide strategy have been raised with NSW Health on six occasions.

The Commission was represented at the Suicide Prevention Forum last year and reiterated the Child Death Review Team recommendations during the discussion.

(c) The CDRT found that there is a need for the *NSW Suicide Prevention Strategy* to address the issue of the association between HSC stress and suicide, and for an urgent investigation into ways in which to support young people undertaking the HSC. In its 2003 Annual Report, the CDRT notes its concern that the finding of Higher School Certificate-related stress is not fully addressed (*CDRT 2003 Annual Report* p 91). Does the CDRT plan to approach the Centre for Mental Health directly on this issue?

The NSW Government is evaluating aspects of *Families First* on a local and state wide level.

This includes the development of a whole of government evaluation framework, regional reviews and specific service evaluations, including a review of NSW Health's home visiting strategy.

The *Family Help Kit* has not been evaluated. The Child Death Review Team will form a view once it has received the evaluation report.

(d) The CDRT found that there is a need for the *NSW Suicide Prevention Strategy* to address the issue of the association between HSC stress and suicide, and for an urgent investigation into ways in which to support young people undertaking the HSC. Has such an investigation occurred and, if so, what initiatives and methods were recommended to assist young people as a result?

NSW Health has not yet reissued the Suicide Prevention Strategy, so no recommendations have yet been made on this issue.

I am not aware of any specific investigation of ways to support young people undertaking the HSC being undertaken by Government.

The NSW Department of Education and Training has included some new information about coping with stress and exams on the HSC website.

I understand that the Department of Education and Training is working with the Centre for Mental Health on developing resources to support young people through exams.

NSW Health may be able to provide further details about the revised Strategy.

(e) Have the related strategies identified in the report e.g. drug education, road safety and crime prevention been linked to the *NSW Suicide Prevention Strategy* and, if so, to what effect?

NSW Health has not yet reissued the Suicide Prevention Strategy, so it is not known whether these linkages are being made.

NSW Health may be able to provide further details about the revised Strategy.

6. Family Dysfunction - The report indicates that opportunities had existed for intervention early in the lives of children and young people in this sub-group but were often lost due to inadequate risk assessment and deficiencies in protective casework. What was the Department of Community Service's (DOCS) response to this finding and what measures/initiatives could be taken to improve risk assessment and protective casework by DOCS, especially with those children and young people who came to DOCS' attention when they were already in extremely high-risk lifestyles (pp73-74)?

The study shows that the children and young people not only received inadequate service from the Department of Community Services, but also from other human service agencies.

In response to this finding, the Child Protection Senior Officers Group, which is chaired by the Department of Community Services, has conducted a small review of the Interagency Guidelines for Child Protection Intervention and interagency practice. This review sought to identify barriers to good interagency practice and to the use of the Guidelines. The Senior Officers Group has commenced updating the Guidelines.

The Department of Community Services is also undertaking research on initial intake and assessment at the Helpline to develop and implement a system that more accurately identifies immediate safety concerns and initial risk of harm. The system will improve the

ability of the Department of Community Services to match appropriate interventions with safety concerns and level of risk and, where appropriate, make referrals to other services.

In addition, the Department of Community Services' major reform program for improving their responses has commenced and should proceed. It includes some measures targeting high need young people. However, we need to recognise that this is a very difficult client group and there are no easy service solutions when problems have advanced that far.

A service system that works for these young people would probably have features like consistency of staffing by workers with whom the young people could develop relationships over time, integration of service delivery by all agencies, allowing the young person to move seamlessly from service to service, and a focus on maintaining connections to education and family and/or peer relationships if possible.

7. Has the CDRT been advised of the outcomes of evaluations conducted into:

(a) the *School-Link* program and other school-based initiatives such as *MindMatters*; and

(b) the development of an Aboriginal and Torres Strait Islander suicide prevention program and related culturally appropriate programs;

(c) Strategy 2.1.4 of the *NSW Suicide Prevention Strategy* [Enhance local youth mental health and related services];

(d) Strategy 3.2.1 of the *NSW Suicide Prevention Strategy* [Improve education and training of primary heath care workers and general practitioners]; and

(e) Guidelines for Australian media professionals under Strategy 4.3 of the *NSW Suicide Prevention Strategy* [enhance local community capacity to prevent and respond to increases in suicide]?

If so, what is the CDRT's view on the outcomes?

Several of these evaluations have started, however none has been completed yet.

NSW Health has commenced a statewide review of School-Link in collaboration with the Centre for Mental Health and the Department of Education and Training.

An evaluation of MindMatters is being conducted by the Hunter Institute of Mental Health.

Several programs addressing suicide prevention initiatives for ATSI Communities are being evaluated by the Commonwealth Department of Health and Aged Care.

No formal evaluation of the Guidelines for Australian Media Professionals has been undertaken.

The NSW Suicide Prevention Strategy is currently being reviewed. The revised Strategy has not yet been released by NSW Health. NSW Health may be able to provide further details about the revised Strategy.

Chapter Four - Follow-up to Question taken on Notice (hearing 23/11/2004)

Mr Steven Cansdell:
You have talked about a report on bullying and its connection with suicide and threats of suicide. Recently a son of one of my constituents has been bullied consistently. Do school principals have a role to play in lessening the impact of bullying, and possibly in mediating with young people?

Response:
Associate Professor Ken Rigby has reviewed international and Australian school based anti-bullying programs and identified a number of factors in effective school anti-bullying programs. These include:

- awareness raising exercises such as surveys and discussion groups to identify the nature and extent of the problem;
- agreement and acceptance by staff on what constitutes bullying;
- education for staff on the short and long term negative consequences of bullying for victims and perpetrators;
- staff awareness of Departmental policies and
- the development of an integrated whole-of-school strategy to address bullying that is well supported by the school and parents.

Programs need strategies to prevent bullying as well as action to deal with bullying incidents.

Research indicates that the most important requirement for successful anti-bullying programs in schools is the commitment of staff to implementing a program. This suggests that the process of developing and implementing anti-bullying programs is as important as program content. Leadership by school principals is essential.

Chapter Five - Transcript of Proceedings (25/11/04)

REPORT OF PROCEEDINGS BEFORE

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

———

REVIEW OF SUICIDE AND RISK-TAKING DEATHS OF CHILDREN AND YOUNG PEOPLE
A REPORT OF THE CHILD DEATH REVIEW TEAM

———

At Sydney on Thursday 25 November 2004

———

The Committee met at 10.00 a. m.

———

PRESENT

The Hon. J. C. Burnswoods (Acting Chair)

Legislative Council	**Legislative Assembly**
The Hon. K. F. Griffin	Ms S. R. Cansdell
The Hon. A. Catanzariti	Mr B. J. Collier
The Hon. M. J. Pavey	Ms D. V. Judge
Ms S. P. Hale	

BEVERLEY RAPHAEL, Director, New South Wales Centre for Mental Health, 73 Miller Street North Sydney, sworn and examined**:**

ACTING CHAIR: Can you tell us the capacity in which you are appearing before us?

Professor RAPHAEL: Yes. I am a professor, a medical practitioner and psychiatrist. I am Director of the Centre for Mental Health.

ACTING CHAIR: We have sent you a number of questions, and I know you have not had much notice because a number of them are based on the session we had with Gillian Calvert on Tuesday.

Professor RAPHAEL: Yes, that is right.

ACTING CHAIR: Do you want to make any opening statement before Committee members go into those questions?

Professor RAPHAEL: Yes. First of all, I will be able to provide a response to all of them but a more detailed response may need me to put evidence before you on notice. I will be happy to prepare that and do it should you require it. The second thing is, I am very pleased to be here. I am strongly supportive of the Commission's work and I am a strong advocate for the needs of children and adolescents, particularly with respect to mental health. I believe it is one of the biggest epidemics we have and we have to address it. The Commission is doing a great job in that regard and I am happy to respond to the issues raised.

ACTING CHAIR: We are happy to have you here to help us with this. We have prepared our questions under a number of different headings. I might start, and other members can raise the ones that they want. The second part, headed "Matters arising from evidence given by Gillian Calvert" may be the area you need to take on notice.

Professor RAPHAEL: Yes. Because of the active work we are doing I can respond to some of it, but more of it might need a detailed response.

ACTING CHAIR: Do you want us, then, not to go into those questions?

Professor RAPHAEL: No, I am happy for you to go into them, and I will add on to them by material sent in if that is not comprehensive enough for you.

ACTING CHAIR: The report deals with the findings of a collaborative research project undertaken by the Commission for Children and Young People. Can you tell us what approach is taken to conducting this collaborative effort and, in particular, the contribution the Centre for Mental Health made to the study?

Professor RAPHAEL: The Centre for Mental Health saw the study as a high priority. We provided some funding some years ago and we also allocated one of our officers who is no longer with us, so She is not able to be here, who contributed to some of the scientific and thinking components in the earlier stages, but the work has been done by the Commission

and its research officers. The aim was to explore and understand better these deaths of children and young people, and the report addresses those issues and the findings of the Commission and the study. We provided data wherever required and we are happy to collaborate in an ongoing way in roles such as this.

ACTING CHAIR: In relation to the matters that arose from Gillian Calvert's evidence, we have a number of different questions. Would it be easier for you to go through them and make a comment?

Professor RAPHAEL: I will start that way, and if people want me to expand, you could interrupt and indicate. The first bit talks about the suicide prevention strategy, which is a whole-of-government strategy signed off and released initially in 1999. It was a strategy that addressed suicide prevention in terms of the evidence available at that time. As it is a whole-of-government strategy, we have been conducting a number of processes aimed at revising that strategy. In addition, we have provided some very detailed processes for assessment which back up the strategy, and I will leave a copy of this for you.

This has only been released since the report has been released and it is a framework for suicide risk assessment and management, which goes into more clinical detail. While it does not specifically speak to children and young people, it is applicable to that population as well. In addition, we are doing further work with children and young people. A whole-of-government forum was held and there is a revision committee, a monitoring committee, set up that I chair and which has met recently and will be continuing to meet. Another meeting is occurring before Christmas.

ACTING CHAIR: Children and young people are specifically included?

Professor RAPHAEL: Specifically included, and we have written to the Commissioner to seek representation as well on the committee.

The Hon. MELINDA PAVEY: One of the things that stuck out with me in reading the report was that only 40 children or young people had a school counsellor file out of the 184. You just mentioned the suicide prevention manual, which is a Department of Health initiative. When you read the case stories, there are so many of these kids. I am mind boggled why there was not a school council file on some of these students, and is that one area where you are concentrating on?

Professor RAPHAEL: We have been well aware of data that goes back a long way but was highlighted by the national study of mental health and wellbeing in children and adolescents, which made it very clear that children and young people do not turn to mental health professionals but rather to related professionals like, in the school setting, teachers and school counsellors, if they are going to seek help at all. The report highlights the unwillingness of children and young people to seek help generally, and I can talk more on that matter.

Since 1999 we have had a program called School Link, which was one of our suicide prevention strategies. I will leave this for everyone to look at. We work in partnership with the Department of Education and Training and school counsellors. We have a training program

which heightens the capacity of school counsellors to detect and respond to depression, suicide risk taking in young people and to find a pathway to care in the mental health service. It is a jointly badged project. It is very important. It has been evaluated at one level and it is being evaluated further. At a meeting with David Mackay from the Department of Education and Training two weeks ago we have agreed to further deepen and extend it.

Other programs funded by the Australian Government include Mind Matters, which also picks up broader issues with schools, and we have linked to schooling some strategies which aim to deal with depression and anxiety in children and young people and which were developed from a research base at the University of Queensland and subsequently Griffith University in Queensland and which helped give children coping skills to better deal with depressed feelings when they come and vulnerability factors in their lives. So, this program, which is building progressively over the years, is an important response to the need to strengthen links with school counsellors and school counsellors' recognition of and response to depression and suicide risk in young people.

The Hon. TONY CATANZARITI: Could it be seen that the children that are seeking help are being helped but the children that are a bit more reserved and not trying to seek the help for reasons best known to themselves are being left out? Could you elaborate on that?

Professor RAPHAEL: Yes. I think there is always a risk that children and young people, and even adults, will be left out because their depression or anxiety prevents them from seeking help or by withdrawing into themselves. That is a big problem with mental health generally. It is added to by the stigma of seeking help for mental health problems which often makes people feel that, if they are not coping, it is some reflection on them personally rather than reflecting an illness condition. So, yes, it is a vulnerable group. We educate school counsellors about it as a pattern of behaviour which might be indicative of risk whether the child approaches them or not, but we cannot be sure that children will be picked up on every occasion. It is true that there are clinical instances of suicide, less obvious in this report, where there has been much pathology in what has been found, but where children in very well-to-do circumstances have killed themselves and have been quiet and withdrawn and nobody expected it.

The Hon. TONY CATANZARITI: What do you see that could be of help to that particular group of people that we are talking about? Is there anything that can be explored?

Professor RAPHAEL: Several things come into this. First of all, more education in schools, but not focused just on suicide per se because there is some evidence that that can increase suicide behaviours if it is focused on the details of suicide. The focus needs to be on the things that might lead to suicide, like depression, anxiety conditions, with some young people the beginnings of psychosis. Certainly the issue of substance use comes into this as well. Many young people may be self-medicating with illicit substances, such as cannabis or some of the party drugs, in an attempt to deal with feelings.

So many of those factors may be seen as solutions as compared to seeking professional help. So I think there is a need to have better awareness that you can get help. Some of the initiatives previously under the National Health and Medical Research Council on the guidelines for adolescent depression, for example, were helpful in that regard because they provided a range of handouts for children. We have a resource called the Family Help

Kit, which talks to families about what you can do if your child appears to be depressed and how to take notice of those signals. But it is true that even so young people may be resistant and it may be difficult to tell.

The Hon. TONY CATANZARITI: When Dr Calvert was giving her evidence there was a question of antidepressant drugs that children are taking, and the concern that I and others around the table had that day was how can they easily get these antidepressant drugs if they are not really what they should be taking? Do you see that as the doctors' profession easily giving it to them?

Professor RAPHAEL: I think there are two issues. I will set aside the psycho-stimulants, which are used for ADHD, separately, because New South Wales has a monitoring system for those and I have previously given evidence on that. That is a separate issue. But if I talk now about the antidepressants, there is currently concern, particularly about the SSRIs, the newer patterns of antidepressant use—selective serotonin reuptake inhibitors—and that concern has been that they might add to depression or suicidal behaviour. On the other hand it is a sad comment. We know that many young people are becoming quite severely depressed, attempting to kill themselves and often at quite young ages, even as young as nine and 10 in some instances. So this is a matter of grave concern. There is international agreement and evidence that the illnesses that we thought were just adult illnesses are coming on at an earlier age.

Three independent studies have shown there is a dramatic rise of depression in the early to middle adolescent years in young women, particularly, but also in young men. So there is a balance between knowing if this is depression that requires treatment and, if so, is it better to have psychological treatment, such as psychotherapy or cognitive behaviour therapy, or is depression so severe or the specific form that might require antidepressant medication, and then there is the series of choices that would be made. I certainly do not believe antidepressants should be used loosely. They should be used when there is a strong clinical indication, particularly in this younger age group. Now with respect to the concerns about the SSRIs, these newer antidepressants, there is great caution. We are closely monitoring the views of the Therapeutic Goods Association and the adverse drug issues, which have been put before the public and before doctors as causes of concern.

And the need for great caution in prescribing these antidepressants is highlighted by the findings and the work also carried on in America about vulnerabilities that might be associated with the use of that particular form of antidepressant drug. On the other hand, we know children or adults who are severely depressed when they start on antidepressant medication quite frequently have suicidal thoughts anyway, and that early time of medication they may become more active, so it is a time of risk that we would monitor regardless of the type of antidepressant anyway. So in an ideal world a child psychiatrist would prescribe these drugs, but we do not have enough child psychiatrists in this country let alone in this State to meet all of those needs. So great caution is essential. They should not be prescribed widely. There is a range of treatments for depression in children, but some children may be so severely depressed that this is an appropriate treatment.

ACTING CHAIR: Following up from that, we also asked you about whatever statistical information was available on this issue. Are you able to take that on notice?

Professor RAPHAEL: I am happy to take that on notice. We know that up to 24 per cent of children and young people suffer depressive illness by the time they are 18, so that is almost one quarter. We know in three separate studies that between 25 and 30 per cent, and at least 20 per cent in the most minimal findings, are likely to be depressed in mid to late adolescent years, and that is a very chilling statistic when you think that once you have had a major depressive episode you are more vulnerable to a second one and a third one. So it is critically important that early intervention is a part of our response, and the department and NSW Health is committed to that. We have a policy called Getting In Early, which looks at that issue and that is part of the focus of our programs in schools as well as clinically in these services.

ACTING CHAIR: Do we have statistical information on the amount of prescription of antidepressants?

Professor RAPHAEL: That information is held by the Commonwealth. We could check that information for you. It is not held by the State Government.

ACTING CHAIR: Does it identify whether prescriptions are for people under 18, for instance?

Professor RAPHAEL: I will check that for you.

Mr STEVE CANSDELL: With the obvious overprescription of antidepressants, in country New South Wales—I mentioned this the other day and I will repeat it here—there is a dire lack of resources and child psychiatrists, therapists and counsellors, and it is far easier and probably the only option for many of the doctors, because to get these children into counsellors and therapists at early stages is almost impossible.

Professor RAPHAEL: Yes.

Mr STEVE CANSDELL: Unfortunately, it seems that there is more prescription because it is the only option available, especially in country and rural New South Wales.

Professor RAPHAEL: Yes, I understand that. I have been a country GP in another life, and I know that that is a very big issue. We have a very strong commitment to building services in rural areas, and we have an initiative called CAMHSNET, which is developing networks of child and adolescent mental health expertise to respond to the most severe problems across rural New South Wales. We now have a child psychiatrist in the northern area, in Lismore, one in—

The Hon. MELINDA PAVEY: It is booked out for months.

Professor RAPHAEL: I know.

The Hon. MELINDA PAVEY: I wanted to put that on the record. It is great that it is there, but it is a problem.

Professor RAPHAEL: Yes, it is part of building the beginning of the service is really what I am saying. There is one in Orange and there is also one in Wollongong. The aim of the

public sector component of this, let alone the private sector part, is to facilitate and strengthen all of the components of service and to provide backup for the GPS as well. But I agree with you, we need to, and we are committed to, build more extensive services for children and young people. I go into bat for these every day across the rural areas as well. The other thing that we do with the rural areas is CAPTOS, the Child and Adolescent Psychiatric Telemedicine Outreach Service, which provides the tele-psychiatry assessments and visits to rural areas of psychiatrists and psychologists etc, to assist in building skills in rural areas and provide expert consultation.

Mr STEVE CANSDELL: I was at a mental health forum on Monday night, and they said that the Northern Rivers has half the funds per capita, or per head, than the rest of New South Wales and unless they are critically diagnosed or have extreme diagnosis they are not even seen. I am hoping that recommendations come out of these reports that call for more funding for those areas of need.

Professor RAPHAEL: I strongly support the need to develop child and adolescent mental health services. I think that is a critical issue. We can have all of the recognition of suicide risk and vulnerability, but unless we have the people on the ground. I might add, work force is a problem across the country, but it is something that we are very committed to changing and to building those resources. But your support would be much appreciated.

Mr JOHN BARTLETT: I was interested in your comment that 24 per cent of children under the age of 18, or adolescents under the age of 18, are going to suffer from some form of depression.

Professor RAPHAEL: Yes.

Mr JOHN BARTLETT: And then once you have had one, it is much easier then to have the second and third.

Professor RAPHAEL: That is correct.

Mr JOHN BARTLETT: Of that 24 per cent, how many would have a second or third incident of depression?

Professor RAPHAEL: I could give you the statistics that are available about second and third episodes, but I do not believe they are clear enough about this population because the statistics that are available that say you have a 50 per cent chance are from studies of clinical populations, not the broader population. So I do not know how they would apply to young people in this setting. It may be more likely, it may be less. So they have not followed up this group. They have mostly followed up adults who have had an episode of depression and then looked at do they come back into services again. So the epidemiological studies show that quite often, even when you have had an episode and it has been treated, you are left with residual symptoms of depression, which make you more vulnerable to getting depressed again.

Mr JOHN BARTLETT: Leading on to the questions we have here, do you know what programs are in place by the Department of Health and the Department of Education and Training aimed at skilling up the emotional capacity of children and young people?

Professor RAPHAEL: There is a range of programs. One of them is called the Resilient Adolescent Program, or RAP, and that is a program that is in some of our schools, but not all of them. In addition, the Department of Education and Training, following my meeting the other day, is committed to how we can strengthen those programs across schools. There are other programs in a similar vein that are built on Australian and overseas research, and I believe they are useful and important. Similarly, some of the programs in Mind Matters look at building coping skills.

Mr JOHN BARTLETT: You are aware of the PPP parenting program and research that has been done there?

Professor RAPHAEL: Yes. It was done in my department when I was at the University of Queensland. Professor Sanders worked for me at that time, so I am very familiar with the program and I am a strong advocate for it, in particular the model that was used in Western Australia, which was used at a population basis. It was a study where community nurses provided parenting skills training and programs to a community of highly disadvantaged families, and then this was evaluated and followed up compared to a similar community that did not have this intervention. They showed a 37 per cent decrease in conduct disorder problems in preschool children, which lasted for two years and that is compared to the control population. That is a very big effect for a program like this.

We have developed some parenting programs, not every area has had them. We have trained several thousand parents in New South Wales who have been to those programs. But, again, we have not had a uniform pattern across the State. Under the Third National Mental Health Plan, which is the plan supported by the States and the Commonwealth Government under the National Mental Health Policy where we all signed up to agree, the importance of parenting programs has been highlighted and will be reported on annually by each State as a requirement for an orientation of the third plan. So the PPP program is, I believe, an excellent program. It is adaptable to a community-based approach. However, it is quite expensive to get a licence to do it and that is one of the issues we are dealing with currently, but in my view it can contribute to building skills from the earliest stages and to lessening the risk of the negative behaviours of conduct disorder, which can have the trajectory into depression in adolescence.

Mr BARRY COLLIER: Of the 24 per cent you mentioned who suffer with episodes of depression, what percentage of those—you may not be over to me this offhand—have been involved with illicit drugs?

Professor RAPHAEL: We do not know that. There is a lot of data recently trying to look at illicit drugs, and the relationship to depression and anxiety. And there is debate about which comes first, the chicken or the egg. In fact, this week I reviewed a paper on that matter, which is not yet available publicly, and there is a very high correlation between the illicit drugs and depression, particular, particularly so in young girls and girls but also in adolescent boys, and the rate is highest, the correlations are highest, with cannabis. I cannot

provide those figures for you because that is not published yet. I was just one of the reviewers. I expect that it will come out shortly.

Mr BARRY COLLIER: In my experience as a legal aid solicitor at a Local Court, I found an increasing number of young men, particularly in custody, having a psychotic episode related in many cases, the psychologist said, to cannabis or induced psychosis.

Professor RAPHAEL: Yes.

Mr BARRY COLLIER: With these depressions, is there a relationship between violence and issues of depression that are coming out in your studies among these young people?

Professor RAPHAEL: I cannot tell you the answer to that. Certainly, coming back to your comment about psychosis, that is a major issue of concern. There is much debate in the scientific literature about whether cannabis causes psychosis in those who are not vulnerable and whether it precipitates it in the vulnerable. Similarly the other psychoactive drugs such as ecstasy and the amphetamines have been long known to cause drug-induced psychosis. In our work with the Drug Programs Bureau I am informed that many people, the younger included, will take a handful of drugs and be quite unaware of what the content is.

I am also aware that while there are some reports of cannabis smoking going down, there are quite significant reports of it not going down, and the issue there is the frequency with which it is a drug of "recreational use"—a term which I put in quotation marks. It is often seen as quite harmless and it is difficult for people to believe that it might contribute in the way that it does. The scientific literature is leaning towards it certainly having a role in precipitation and possibly in aetiology. One of my staff and another colleague have just completed a review of this matter and as soon as the paper is completed I would be happy to let you have it in confidence because it is not yet published.

Mr BARRY COLLIER: It just seemed to me that suddenly, for no reason at all, you had a young man who decided to smash up the family home and beat up his mother, and the only connections appeared to be some recent, growing habit with cannabis.

Professor RAPHAEL: Yes.

Mr BARRY COLLIER: But not every child was doing that.

Professor RAPHAEL: No, and not every young person or person who takes cannabis is either.

Mr BARRY COLLIER: That is what I meant.

Professor RAPHAEL: Yes. I think the issue is that many young people take cannabis and a range of other things, so it is easy to highlight the cannabis but less easy to know what complex mixture they might have had at a party or in their drinks. Many factors might be contributing. There is concern, however, in the scientific literature about the role of cannabis.

The Hon. MELINDA PAVEY: And people's predisposition.

Professor RAPHAEL: Yes, and certainly if there were a family history of psychotic illness, one of the most important things you would do is try to advise against any cannabis use.

ACTING CHAIR: Mr Collier's question specifically mentioned violence.

Professor RAPHAEL: Yes.

ACTING CHAIR: Is it the case that the kind of violence he is talking about is also related to violence against the self, suicide and self-harm.

Professor RAPHAEL: Yes, it is, and particularly for young men. There is a spectrum and some research that suggests it is that impulsiveness of violent acting, what we call acting out behaviour, which increases the likelihood that one might be violent toward oneself. There is one study that I think is commencing through the suicide prevention institute in Queensland, which is trying to look at single vehicle accidents, for example, and whether that, for some who die in that way, is potentially a suicide-related death.

CHAIR: This is an observation of violence of the kind Mr Collier talked about.

Professor RAPHAEL: Yes, that is right, and that aggressiveness may well be turned to the self in suicide-related death.

Ms SYLVIA HALE: I would like to ask some questions about children in the care of the State. Is it appropriate now to go on to that, or do you want to continue the line of questioning?

CHAIR: Are they related to the report?

Ms SYLVIA HALE: Yes. They are related really to the fact that the University of New South Wales research showed in 1996 that some 57 per cent of State wards have thought about committing suicide, and 35 per cent had actually attempted to do so. In the Senate Community Affairs Committee's report of August 2004, "Forgotten Australians: A report on Australians who experienced institutional or out-of-home care as children", recommendation 25 was that the Commonwealth and State governments, in providing funding for health care and in the development of health problem prevention programs—especially mental health depression, suicide prevention and drug and alcohol prevention programs—recognise and cater for the health needs and requirements of care leavers. My question is: Are you aware of any programs, research or analysis that specifically deals with children in the care of the State, and those who have left the State's care, regarding their mental health and suicide rates?

Professor RAPHAEL: No, I am not aware of that. I can take that question on notice and look but I am fairly aware of the literature and I think that while it is recognised this is a group with a high level of need, I am not personally aware. But I will take it on notice and find out for you. Could I just comment that most children in the care of the State have an accumulation of risk factors. It would be no surprise for them to have a high rate of both

suicidal ideation and suicide-related behaviours because they frequently have a history of abuse, family disruption, adverse socioeconomic circumstances, experience of violence, interruption of their learning development through schools—every adverse risk factor you can think of is likely to have been present for their background. So even when they have been in good care, and that may be reparative to some degree, it is highly unlikely to totally wipe out that level of risk. And we know, for example, that if they have been abused as children, that heightens the risk very significantly.

Ms SYLVIA HALE: It is my understanding that they are 25 times more likely to die in police presence or juvenile detention than are non-State wards. Do you have any understanding or knowledge of their involvement in the mental health system and the nature of the services that might be available to care leavers?

Professor RAPHAEL: I think first of all that this has been a group that frequently has not got into contact with mental health system, although I know the work that Professor Nunn is undertaking in Newcastle through the Nexus unit is looking very much at young people like this and is working closely with the Department of Community Services. However, I think that the issues are that young people from such circumstances frequently pass into a range of developmental trajectories which have a series of potential negative outcomes, like juvenile justice. I am not saying that it is the fate of everyone but there is a vulnerable trajectory forward which can lead to that and I know that such children are certainly more likely to die prematurely either as children or adults.

ACTING CHAIR: You will take on notice whatever information or studies are available.

Professor RAPHAEL: Yes, I will take that on notice. I do not have it to hand and it may be that there are some studies; I do not know. It is not in the general literature but we will certainly seek publications on new case studies.

ACTING CHAIR: We do have some questions in the ones we sent you, in a little section headed "Family Dysfunction", and some of what you are saying relates to that.

Ms SYLVIA HALE: Are you aware of any care leavers being involved in any advisory groups or ministerial committees? Have they ever actively been engaged?

Professor RAPHAEL: I cannot comment there. I do not know. But I have forgotten to highlight for you that under the Government's response to the upper House inquiry and its recommendations, we have a range of senior officers groups [SOGs] and what we call mini-SOGs addressing many of these issues. One with the Department of Community Services is looking at care leavers among that group.

ACTING CHAIR: I think some of Ms Calvert's advisory groups and so on, including, I think, the one from the Drug Summit, have included children who are, or have been, in care. We can follow that up.

Professor RAPHAEL: Yes.

Mrs VIRGINIA JUDGE: I am particularly interested in 17-year-old and 18-year-old students who have just gone through their Higher School Certificate [HSC].

Professor RAPHAEL: Yes.

Mrs VIRGINIA JUDGE: I am concerned about the impact of that in terms of adolescents' mental health. I know that it causes stress. Obviously, anyone who is sitting an examination goes through a certain amount of anxiety and most people seem generally to be able to manage that, but I have spoken recently with a number of doctors and some of the doctors have said that particularly during that period they have seen a large proportion of young people who are seeking medication. I think that is something that needs to be looked at. I do not know how you get the statistics because of privacy issues, but obviously they are prescribing medication so there would be some way of tracking what is happening at that time. It is not just the examination. A lot of the things I am hearing from a lot of adolescents is having to put down their subject choices, their career choices, before they actually get their result.

The feeling I am getting from these 17-year-olds and 18-year-olds is that, if you are really clever, that is fine because you look at the book and you go through all the categories. I have one child who did it last year and another one has just done it this year. If you are academically gifted, you can say "Okay, that is the mark I should get to do that job or that course", but the bulk of young people, their marks fall in the middle category and they look every year, and every year the prerequisite mark is going up. They are saying, "We are aiming for that", and the whole process is generating a lot of stress and anxiety among young people. I am just wondering if there are any studies being done on this and any possible ways that the Commission can look at this issue, or whether there is anything we can do?

Professor RAPHAEL: I think it is a very worthwhile area to study and it certainly is perceived by young people and their families as a very big source of pressure. I know the education department is actively addressing it. They have a number of programs for handling stress in relation to the HSC, and I could send you copies of those if you are interested. We certainly have been asked every year to comment on mental health issues by the media with regard to these matters. I think it is just a recognition that there are a number developmental points which are extremely stressful, but I gather that at least the New South Wales education department is trying to put in place programs that young people can use to address stress.

Mr JOHN BARTLETT: Professor, staying with this age group—the 17-year-olds and 18-year-olds—70 per cent of the children who died were suicidal or risk taking. Of that group, 70 per cent were children at school and it was mostly interpersonal conflicts at school, such as relationship breakdown. Do you think there is a link between that and the previous question?

Professor RAPHAEL: About stress?

Mr JOHN BARTLETT: Yes.

Professor RAPHAEL: Yes. I think when you look at the precipitants as opposed to the longer term risk factors for suicide, it is quite often a relationship breakdown of some kind or

some experience of humiliation or rejection that is often the near-time thing to a suicide attempt or a suicide act. You may not know what it is. One of the problems that I should have taken up with one of the previous questions is that there is quite often an unwillingness among peers to tell what they know about someone's suicide-related thoughts or potential actions because they feel that is dobbing. So part of the advice that the Department of Health and the Department Education and Training provide is that this is not a private matter. If you are thinking that, nobody should be keeping that secret from others but should be letting others know that the person is vulnerable or is at risk. So certainly the strain of examinations may put a strain on relationships. We know, for example, of other vulnerabilities about relationships in a study that John Howard—not the Prime Minister but one of the academics—that showed young people who were gay were very vulnerable about coming out. Prior to the time they came out there was an increased risk of suicide-related behaviours

The Hon. MELINDA PAVEY: You mentioned the mental health facility at Newcastle.

Professor RAPHAEL: Yes.

The Hon. MELINDA PAVEY: There is also one at Campbelltown.

Professor RAPHAEL: Yes.

The Hon. MELINDA PAVEY: Could you just explain their roles and add any thoughts or plans to roll them out to other areas of the State.

Professor RAPHAEL: We have plans and funding to roll them out to other areas. There are a number of child and adolescent mental health in-patient facilities in New South Wales and we have been increasing the number of beds. Previously there was the view that children did not suffer serious illnesses; they have behavioural and emotional problems but they did not get really sick. That view has been put aside by the recent evidence; the findings of the Commission highlight that as well. There is evidence that even psychotic illnesses are probably coming on at an earlier stage. The Nexus unit, which currently runs the network across New South Wales of supportive nurses, is one unit. It is a 12- bed in-patient unit that can take severely ill children, and it does. I have been through a list of the children who have been admitted and quite often many of them have been wards of the State at one stage or another, or have been in care.

The Hon. MELINDA PAVEY: That is at Newcastle.

Professor RAPHAEL: That is at Newcastle. The unit at Campbelltown has 10 beds. It has had trouble getting staffing, and it is only recently getting to a more complete staffing level to open it because of the work force shortages in this specialised area. There is also Redbank House at Westmead Hospital. We have recently funded two additional units, one at the Sydney Children's Hospital with eight beds, and one at the Children's Hospital at Westmead with eight beds. They are progressively opening, again with problems about staffing—there are shortages in nursing staff and child psychiatry. In addition, there are longer standing units at Coral Tree House in the North Sydney Area Health Service at Macquarie Hospital and Riverdell, which is at Concord, as part of the Central Sydney Area

Health Service. We have a roll-out proposal to the Northern Rivers, at the new Richmond Clinic being built at Lismore, and at Orange and in the Illawarra at Wollongong.

ACTING CHAIR: What links are there between the special units that the Department of Education and Training runs for behavioural, disordered or emotionally disturbed children and adolescents? Are they linked to the health facilities or do their clients tend often to be amongst the group we are talking about?

Professor RAPHAEL: I think with the behavioural and emotionally disturbed that the education department runs we might provide care, but it would usually be in the community unless the child from that setting escalates in their illness or condition. Much of that, however, is managed by the Department of Education and Training within the educational framework and with appropriate backup in some instances. They have a range of special classes. I was quite stunned to hear the numbers of special classes they have and it might be useful for you to have that information and I could forward it to you, because they have classes looking after a range of disturbed and difficult behaviours.

ACTING CHAIR: It might be easier for us to take that up with the department ourselves through David Mackay.

Professor RAPHAEL: Yes. Sometimes the clients would come into the service. The clients come from a range of different referrals. They may come from general practitioners [GP], from mental health services more broadly, from community health services, or from paediatricians. One of the things that CAMHSNET does is provide nurses to back up the care of younger children in paediatric units when their primary diagnosis is a major mental health problem.

ACTING CHAIR: How many of the children and young people who go through the Department of Education facilities are or are likely to be in the suicide and risking-taking risk group?

Professor RAPHAEL: We do not know. Suicide thoughts are quite common and I could provide you with data on how frequently they occur. It is fair to say that for many of the younger children that is not the critical issue, but sometimes it is. I think schools are now much more aware of those issues. They are very sensitive to them and would probably pick them up, but it is often hard to know because, as came up in previous questioning, children may not communicate that and they may seem good because they are not being aggressive. It is the quiet, very good child who may be sinking into a severe depression.

The Hon. MELINDA PAVEY: In relation to family dysfunction, 60 per cent of the children in the study had to have enduring difficulties and, essentially, I see that as family dysfunction. What was the Department of Community Services' [DOCS} response to this finding and what measures and initiatives could be taken to improve risk assessment and protective casework by DOCS, especially with children and young people who came to DOCS' attention when they were already in an extreme, high-risk lifestyle?

Professor RAPHAEL: I think that many of these matters will be better evolved with the senior officers group between DOCS and mental health. I have had quite a lot of negotiations with DOCS about how we might do better in that partnership and I think that the

trajectory now is much more positive about going forward with that. We do provide, through the Institute of Psychiatry, some training to DOCS workers about related mental health matters but, unfortunately, mental health is such an enormous issue that quite often many of the workers have not had the opportunity for the training necessary on this issue. That is something we will be taking up further.

I do not have control over what they do, so it would be our offer of training and the take up that is the critical issue. For example, mental health issues related to child abuse are seen as so significant that in Queensland there is a special program being funded through mental health to bring mental health issues to the fore and with the aim of better work being done in this field.

The Hon. MELINDA PAVEY: That is interesting.

Professor RAPHAEL: Yes, it is.

The Hon. MELINDA PAVEY: I think any of us, if we had had abusive parents, could have been sent off the edge.

Professor RAPHAEL: Yes.

Ms SYLVIA HALE: Does that work with the abusers or the children who are abused?

Professor RAPHAEL: The work in Queensland?

Ms SYLVIA HALE: Yes.

Professor RAPHAEL: It will be with both the families and with the children.

Mr JOHN BARTLETT: Yesterday Commissioner Calvert mentioned that she thought the kids help line was well identified by young people as being there. If I go back to an earlier question in terms of the 40 per cent that never seem to actual touch base with any school counsellor or anyone, is there a lack of knowledge by that subset of what is available or is it just part of the condition?

Professor RAPHAEL: We know that even with adults' knowledge, access to mental health services is difficult. People feel it is stigmatising. Most people would seek help from their general practitioner. We run a program called Teams of Two, with the Alliance of the Divisions of general practice to increase GPs skills and access to mental health services. That may be one place where some young people can be picked up. But in the most disadvantaged families, they probably do not go to the doctor very often because unless the doctor bulk-bills, they cannot afford to and they may not see it as a solution. In the very dysfunctional families the parents' own distress and needs are so great that they often are unable to perceive the needs of children, whereas for more middle-class families, those issues would be clearer.

I think one of the chilling things is that mental health problems certainly impact on the child's capacity to learn, so you see an impact on their learning trajectory, which then

leads to more distress, so you get a cycle. Our emphasis is on what we might do preventively or with early intervention, but again issues of building work force and the resource base to do this, and having enough workers are extremely difficult, even when you have the funding.

Mr JOHN BARTLETT: So programs like HomeStart, which try to get the abusive situation changed right at the beginning, is probably one of the most effective means of addressing this?

Professor RAPHAEL: Yes. I think that the range of programs under the Families First initiative is very good and they include emphasis on parenting and the perinatal period. We have contributed to some degree to those and we will be doing more in the future; for example, with home visiting and how to pick up and respond to mental health issues in the case of post-natal depression or antenatal depression, as it often is as well. I think there is a range of steps along the developmental pathway, all of which are important in building the strengths, but it is a fact that people may not present to any health care worker, so that the more the community knows and understands, the better.

The Hon. TONY CATANZARITI: Are there any statistics available on what particular groups might be more predisposed to mental health problems, for example, race or country areas versus cities?

Professor RAPHAEL: Yes. For example, there was a study some years ago by Dr Michael Dudley, an expert in the field of youth suicide, which highlighted that in small rural communities of less than 4,000 there was a greater risk of suicide in young people and certainly we put programs in place, and the Commonwealth did as well, to try to address that.

The Hon. MELINDA PAVEY: It has worked, to an extent, according to the figures in the report?

Professor RAPHAEL: Yes, well, we hope it has. It is very difficult with suicide figures because so many variables may influence them, but the rates in young people have gone down.

The Hon. MELINDA PAVEY: In the bush.

Professor RAPHAEL: Yes. Aboriginal young people and Aboriginal older people, if they get older, are at greater risk of suicide and have more adverse health indices. I am familiar with a report, which will come from Western Australia but it is not yet released, that has looked in detail at Aboriginal families and we will be trying to link in some of our data to look at whether the findings can be useful to us as well. It highlights that some families are more vulnerable than others even within the indigenous community.

ACTING CHAIR: What about refugees and their children?

Professor RAPHAEL: Yes, there is certainly more vulnerability but quite frequently less access, and identification of mental health may be more stigmatised in many different in the groups as a sense of personal failure or a range of interpretations. However, we work with the Transcultural Mental Health Centre and, through them, have put out a series of tapes

through SBS and brochures in community languages about the needs of children and young people with respect to mental health. We have an ongoing program of that kind.

Mr STEVE CANSDELL: What sorts of important mechanisms, if any, are in place for families that have had a member suicide. I ask that because very recently at Maclean in my electorate the step-father of a young family committed suicide and within two months, only this weekend, his step-daughter committed suicide, for different reasons. I do not know whether there is anything in place to target families to give them support. I attended a mental health forum the other night where mention was made of the fact that there are no support groups available in the area for families who have had members or friends suicide.

Professor RAPHAEL: There is a national association, with a New South Wales branch, called the National Association for Loss and Grief, which runs support groups after suicide. I could forward you the contact details for that and they could let you know what is available in your area health service. The department funded a program, which has gone out through the health services—and I will leave you a copy—about making people more familiar with bereavement and what they should do in those circumstances.

We have also had what is called a care and support pack for families bereaved after suicide deaths and that should have been handed out to families, but I do not know if it has been. The two most popular publications the Health Department ever had in any area were our family health kit and the care and support pack. I will make sure that copies of that come to you as well. We also have "Supporting Children After Suicide", which was developed in one of our area health services showing what is needed for children in such circumstances. While that is not adequate of course because local services and local support programs are needed, I will leave these for you and give you the contact details.

ACTING CHAIR: How does someone make sure that families get access to that information?

Professor RAPHAEL: If they have any contact with the area mental health services it should have been given out then. Quite often, because of staff turnover, people are not aware and it is one of my most difficult tasks to try to make sure that resources get to the grassroots level. It is a continuing issue because of staff turnover and management turnover and now we have restructure of our areas as well, so that getting systems in place to make sure that the dissemination of material like this gets out to the grassroots level—

ACTING CHAIR: So these materials do not get distributed to GPs, for instance?

Professor RAPHAEL: No. The bereavement pack has been distributed to GPs and we have sent out a lot to GPs. The bereavement resource has been distributed to GPs through their divisions but, again, that might not have gone to everyone. Some things we distribute as far as we can to all the GPs we have contact with through the Teams of Two initiatives or the divisions, but we may not have contact with everybody.

Ms SYLVIA HALE: Just following that up, in the case of suicide, there would inevitably be contact with the police. Has there been any attempt to distribute this material via the police?

Professor RAPHAEL: That is a very good thought and I will take it on board. Thank you. We do fund resources and work closely with the police on a lot of issues and it would be very easy to ensure that this goes through that process as well.

The Hon. MELINDA PAVEY: Very sensible.

The Hon. TONY CATANZARITI: When you mention GPs then, the thought crossed my mind, knowing some of the GPs in my particular area and how busy they are, how do you find they actual go into that because some of the doctors are working around the clock. It must be very difficult.

Professor RAPHAEL: It is extremely difficult and that is why we have this Teams of Two initiative. We usually have a breakfast and the doctors and the mental health workers have it together and they both present issues that are relevant. It was first started as an attempt, but much to our surprise it has become so popular that the drug companies want to purchase it. I am not saying that solves all the issues because GPs are very busy. I was a country GP and a city GP and even in those days it was busy and now it is very full on and competing. There are specially funded initiatives to give GPs funding for a longer time for mental health issues, but I am informed that many GPs see that the paperwork to get that extra label to get access to better mental health outcomes program is so frustrating that they may not join up.

Mr BARRY COLLIER: I have two questions. A GP around the corner faced with a person with the mental health issue who was obviously a potential suicide, sent the person to me—the local member of Parliament—to do something about it. Is there a problem with GPs not wanting to know about this sort of stuff? I rang up the GP and told him what I thought of him—I should have reported him to the Australian Medical Association. It is just disgraceful when there is a mental health team in Sutherland. Do GPs say, "It's not my problem"?

Professor RAPHAEL: I think that is a problem. Mental health takes time, GPs are busy and it is frustrating. They are scared: they may feel that they do not have enough knowledge to deal with the problem. They may be frustrated by difficulties accessing the mental health service. One of the good outcomes in the evaluation we have done of the teams of two is that they have better access to the mental health service and they understand the pressures on that service. I think sometimes their frustration with us has made them act that way.

Mr BARRY COLLIER: This guy would not even make a phone call. I did, and got the mental health team out to talk to this person straight away. Secondly, in my area we have the Sutherland Shire Suicide Safety Network, of which I am patron. It involves the police, the hospital, funeral directors, the local council, local members of Parliament and so on working together. We have money for a bereavement service and we have brochures about what people can do. Is that sort of service fairly common throughout the State?

Professor RAPHAEL: It varies. I think it is a great initiative. There is one on the Central Coast. I did not know you had one in Sutherland. It is extremely important. One of the things we will do in our next audit is see how many communities have those services because I think they are a positive initiative involving people and destigmatising these issues.

Mr BARRY COLLIER: To give an indication of how popular the service is—I say this for the benefit of other members as well—we recently had our fifth partnership day with all the people involved in the mental health area, suicide prevention and so on. More than 100 people attend this event each year, including police and social workers.

Professor RAPHAEL: When was it set up?

Mr BARRY COLLIER: About four years ago. I can give you some information about it.

Professor RAPHAEL: That would be very helpful, thank you. I know of others but I did not know of yours. I probably should have known because I think I stole the psychiatrist from your area, Dr Sara, to come and work with me.

Mr BARRY COLLIER: Yes, I am not very happy with you. He was great.

ACTING CHAIR: Mr Collier will give you some information in return.

The Hon. KAYEE GRIFFIN: You have spoken about Families First and some of the other initiatives that are around. Quite a substantial number of schoolchildren end up in after-school and vacation care because their parents work and so on. Those services are provided sometimes on school grounds by a mix of local government and community-based organisations. Are you involved with those specific services as opposed to early childhood services, which pick up learning difficulties? Some children spend quite a substantial amount of time with other organisations.

Professor RAPHAEL: Yes, it is true. To be honest, we do not have any specific contact. Most of those services are run through links to the education or the private child care sectors and the Centre for Mental Health does not have any specific links to them. It may be a time of vulnerability and I think complex family issues come in, such as parents' exhaustion, if they have a very long day at work; the financial necessities that may drive some of that work; and the guilt that mothers, in particular, feel—I am speaking from my own experience many years ago with my daughter, who now has a son. People often feel that mothers are making a bad choice and parents often questions, "Am I doing the wrong thing?" Lots of issues come into it. But I do not know of any mental health issues in relation to that important area.

The Hon. KAYEE GRIFFIN: It would be difficult because some of these children spend substantial amounts of time in these services and because there is such a mix of service provision. But it might present an opportunity to pick up some problems.

Professor RAPHAEL: Yes, it might. I think that is true. There would also be opportunities to support the parents, who often have to make these choices not because they wish to do so but because they have to because of their resource base and commitments. Recognising parent need as well as child need is helpful. Some of the department's initiatives, such as schools as communities, could usefully take that forward.

The Hon. KAYEE GRIFFIN: The other problem is that younger children tend to have the more intensive care as opposed to primary school age children and children who end up in vacation care on a regular basis.

Professor RAPHAEL: You are absolutely right about that. It is also the fact that they are seen as being able to look after themselves and they may not have the backup to do that in the best way in terms of their development.

The Hon. KAYEE GRIFFIN: You said that nursing services are needed for inpatient care. Are you looking for something different in nursing with regard to children and mental health issues? You referred to the service that is being set up in Orange. Is that based with the hospital or with Bloomfield?

Professor RAPHAEL: It will be with the hospital but it might be with Bloomfield initially until the new hospital is built. There will be provision in the new hospital for it to be part of that. With respect to the nursing work force more broadly, mental health nursing is a major issue across the world. I believe the average age of our nurses is now late forties. It is about recruiting people into nursing, and specifically into mental health nursing. A year or so ago we ran a project looking at what we could do to increase interest and involvement in mental health nursing, particularly as we had to open inpatient centres in many countries areas, such as the new units at Coffs Harbour, Taree and Kempsey. We had to look at innovative ways of recruiting nurses into that setting. We funded some initiatives looking at regional universities that had nursing schools. They are working in partnership with the areas to get more nurses into mental health and to build up the skills of nurses who might have been otherwise trained. We are evaluating how effective that was more broadly to look at some further resourcing of that initiative.

With respect to child and adolescent mental health, some special skills are needed to manage the mental health issues of children and young people. There is very limited training in that area. Through CAMHSNET we have provided a range of skill-building courses. That has been very well received and more courses are coming. But it is a specialised area with great need. We heard recently that more nurses are probably interested in child and adolescent nursing and we are trying to look at how we can work with the universities to build this output. There is also recognition nationally, under the National Mental Health Plan, of the shortage of mental health nurses. The Commonwealth has released a new nursing strategy to address that issue. Nursing, like other tertiary education courses, is a complex mix of what is needed in the States and funded through the Australian Government. It is about looking at what we can do to develop it. From my experience in academic life, it often takes a long time to change courses or to initiate courses. Unless you are incredibly rich and have an enormous amount of money to give it is very difficult to change those courses quickly through the curriculum structure at universities. So we are also looking at how we can do better, quicker.

Ms VIRGINIA JUDGE: The last report contains figures for suicide and risk taking. Do you have any data on what percentage of suicides came from a non-English speaking background? I am picking up on what Tony said about other ethnic groups. I am thinking of Asians, Koreans and Chinese. I am worried about that aspect.

Professor RAPHAEL: Yes. I can take that question on notice and see what data we have. My experience generally—and the data generally suggests this—is that people from culturally and linguistically diverse backgrounds have more difficulty accessing services or are less willing to access them. They may stay longer, at least in terms of adults. I do not have data on the numbers of children and young people at the moment but I will try to find that for you.

The Hon. MELINDA PAVEY: In light of the fact that 66 per cent of children canvassed in the book have had enduring difficulties—basically, family dysfunction—has the Child Death Review Team considered, or is it worth considering, the issue of babies who are born into circumstances that are not optimal, such as babies who are drug dependent? For example, on the weekend I talked to a grandmother who was caring for two children who were both born with drug problems and now have attention deficit hyperactivity disorder. It is a complete nightmare. Considering that so many Australian couples find it very difficult to have children of their own and are going offshore to buy babies, is it worth considering placing a stronger emphasis on adoption at hospitals through maternity wards, where we see children that we know will end up in this book in some capacity?

Professor RAPHAEL: That is a highly contentious and complex issue, particularly as you will be well aware of the parliamentary inquiry and report on adoption and some of the outcomes that were presented through that committee.

The Hon. MELINDA PAVEY: Was that the adoption inquiry of several years ago?

Professor RAPHAEL: Yes.

The Hon. MELINDA PAVEY: It is a different age and a different time.

Professor RAPHAEL: Yes, I understand that fully. I am simply noting it. People would see it as some form of social engineering and I think the sanctions for it would be extremely difficult. I think within the systems we have we can do much better at detecting and working—

The Hon. MELINDA PAVEY: We can do much better.

Professor RAPHAEL: with mothers during pregnancy, particularly considering the high numbers of women who are physically abused during pregnancy, and in the immediate perinatal and early postnatal period. There was quite clear evidence that if we provide more support they will have a better trajectory and their children will have a better trajectory. That is one thing that we should be investing in at a population level. Then the very high-risk circumstances will need very careful monitoring and support. Certainly the issue of adoption is a very sensitive one, as you would know. It is about people's rights to their children.

The Hon. MELINDA PAVEY: I have spoken to maternity nurses about this and that option is not able even to be canvassed at that point.

Professor RAPHAEL: No, I know.

The Hon. MELINDA PAVEY: Some mothers may be prepared and realise the benefits of adoption.

Professor RAPHAEL: Yes, that is certainly an issue that you could consider in this Committee. But I think the social climate is probably not—you would know better than I what society is ready for because you are tuned in—

ACTING CHAIR: Putting on my hat as Chair of the Social Issues Committee, which conducted the adoption inquiry a few years ago, it is certainly a very fraught area.

Professor RAPHAEL: It certainly is. I think I am saying the same thing: there is no easy solution.

The Hon. MELINDA PAVEY: It is also very fraught when we read in today's *Daily Telegraph* about a baby who was punched in the stomach and died.

Professor RAPHAEL: Yes. I agree with you that it is a very painful area and that our investment needs to be significant. One of the big issues with respect to children and young people with a mental health problem is that their parents may not be their advocates to the same degree. Looking at the media, we have more pressure from access block for adults than we have for children who are not presenting for care. So advocacy for children's mental health needs is a major issue that we must take forward. It encompasses families. There is such pressure on adult services—and that is what everyone notices—that the Commission's report and work is so critically important because it highlights the needs of children.

There is very substantial data. NSW Health conducts health surveys that show that almost one in three parents considers their children need emotional help. I could send you that data as well. Whether it is an exaggeration of some kind and it is not quite that many, but most population studies show that between 15 per cent and 20 per cent of children have a diagnosable psychiatric disorder. That is a very high number—it is one in five, as it is for adults—yet the services for children and young people are not nearly as extensive as they are for adults. So, in my opinion and according to the work of other researchers, we have a trajectory of this risk accumulating into adult life.

ACTING CHAIR: I think you said something about this before but, following on in one sense from Melinda's question, the home visiting program under Families First—the home visits to new mothers and babies—to what extent is that tied into the work of your centre in terms of picking up potential mental health problems as well as the range of other problems that the home visiting program picks up?

Professor RAPHAEL: We have worked to put questions into the obstetrics screening database about this sort of vulnerability, and that is moving forward. We have also contributed significantly to the education and training guidelines for the home visitors. So there are linkages like that. The reinforcement of those linkages is perhaps not as strong as I would like.

ACTING CHAIR: Could you expand on that a little? Do you mean it is early days?

Professor RAPHAEL: I mean it is early days and it is also—

ACTING CHAIR: Does it fall between sort of bureaucratic silos?

Professor RAPHAEL: I think it can at times. I mean we have had support about it but it comes back to what I was saying a moment ago that in my position there is so much pressure about the adult mental health services—I have been battling since the day I took this job about the child and adolescent services and we do have a momentum now, but the extent of the problem is not readily accepted because the children do not complain, and frequently their parents are so distressed or dysfunctional themselves that they are either unable to see the needs of their children or are not vocal enough to complain, or get blamed for it if they do. So I think advocacy for this area is one of the most important things any government agency can do.

Mr JOHN BARTLETT: I am still staying with this fact of how children access help and I see the comment here that for just under half of the children and young people the only information available was that contained in the coronial file.

Professor RAPHAEL: That is a tragedy.

Mr JOHN BARTLETT: It is pretty sad, isn't it?

Professor RAPHAEL: Yes, it is. I think building services so that if there is a question people can go and ask the question and get some assessment is an important thing. If they are worried about their child it is easy to access a mental health assessment, a mental health question. There are some quite simple advice and treatments that can work early on in an illness, which, if the problem becomes entrenched, will require a lot more resources. So the more we can spread that sort of information and support through the community the better.

Mr BARRY COLLIER: Just following on from that information, is it a problem that parents confronted with a child that obviously has some sort of mental illness or psychotic episode (a) do not know what to do, (b) do not know where to go, and (c) feel very embarrassed about it? How do we address those issues?

Professor RAPHAEL: All three of those things apply and that is what the national survey showed and what still shows up in surveys. I will send you the report on that so you can have a look at it. The Family Help kit is trying to address that, and we distributed those kits widely. As I said, it was one of the most widely used publications of the health department, but it certainly did not get to everyone any more than the advice to communities of culturally and linguistically diverse backgrounds got to everybody. So that information getting on the public record where you can go and then us having enough staff to respond when people come is a key issue as well.

Mr BARRY COLLIER: Does everybody get a copy of that in their letterbox? How does it get out there?

Professor RAPHAEL: No it does not, it is through health services. A letterbox would be more effective.

The Hon. TONY CATANZARITI: More things come to your mind as you keep listening to what is going on. Do you feel that the changing times that we live in at the moment where

we seem to be always busier, running around, not enough time for virtually anything—going back to the days when we were kids I thought there was a lot more time for everyone; these days everybody is running into such a rut—do you see that, in itself, as a problem regarding mental health?

Professor RAPHAEL: It may be, we just do not know well scientifically about whether that is the case or not. One of the problems we face is that social change is here with us and it is not going to go backwards, so it is how we look at whether we can understand better the impact of the busyness, and how much time spent with the child is critical. For example, more than 10 years ago there was a study that showed that the average father spent a very small amount of time in face-to-face interaction with his children. That has changed more positively and some of the data now, particularly out of the diary studies looking at time use, shows that the time spent by fathers has increased, and that is probably a very good thing for children where the families are intact. But the level of busyness probably impacts on the way families function. I think it would be useful, if the Committee is interested, to look at the work of Professor Michael Bittman at the University of New South Wales, who has done a lot of work with the diaries and time use in families, if you are interested in looking at the busyness issue.

ACTING CHAIR: I have just been looking at some of the questions that we sent you that our questions have not really touched on. One of them, 2 (b), was whether there are any particular suggestions made in the report that the centre sees as priority measures. Would you like to point us to those now or take it on notice?

Professor RAPHAEL: The principal recommendations made to the centre were about the review of the suicide prevention strategy. While I think that that is extremely important, I think that in the case of children and young people we also need to build the services. We can have all the measures about what to do but it is no good if we do not have the services there to deliver when we find a young person at risk. So we are engaged in that task now, but support for that process is a critical issue, in my opinion.

ACTING CHAIR: So this comes back to the imbalance between the availability of services for adults and that for children—

Professor RAPHAEL: Yes. There is still not enough for adults, but for children and adolescents there is a much lower level of service provision.

ACTING CHAIR: Within that area of service provision would you focus on some areas as higher priority than others? Is there a great need for one particular kind of service across the State, for instance?

Professor RAPHAEL: I think there is a need for services which will provide a rapid response so that if a family has a concern they can go and get at least a brief assessment rather than waiting six months for an extremely detailed assessment. A brief assessment and some guidance rapidly may be all that the family needs to go forward and then they can engage in other programs. So we will be emphasising that as we rework issues about services. There is currently a review process, and this afternoon I am chairing a committee on that, looking at how we go forward. We have also got a consultants review of child and adolescent mental health services under way and I am waiting for the report of that.

So I think assessing needs, giving advice, providing information then and there or a response or advice what to do is a good start. So often it has been that there is a waiting list or people cannot access a service and they lose interest and they may go off and it may all go away, but it certainly does not for some people, so the trajectory gets worse by the time they present—if they come—or they lose interest in coming. Because it is that response when you are in need and you take the step for help, it is very important to have a response at that time. I think that is why Kids Help Line is so good; they are instantly available.

ACTING CHAIR: So does the lack of that rapid assessment come back to focussing more on adult mental health or does it come back to the issue of staffing and the shortage of nurses and child psychiatrists?

Professor RAPHAEL: I think it is the shortages across all areas but particularly in child and adolescent, and we are building it up and we are reorienting our services to be more responsive in this way. But we often have not had enough staff to provide a service, and that is changing now. So the Government has certainly made a financial commitment in policy, but we need more backing.

ACTING CHAIR: Is there any other priority measure that you would stress among the various suggestions made in the report?

Professor RAPHAEL: One of the things that happens—you mentioned the parenting programs, for example, and the Department of Community Services is very actively involved in that as well—but some of those programs would be of enormous value. They do not have to be rigid in their application but their availability being extended is important as well as prenatal ones because getting a good start at the beginning makes a big difference. I think we have got a lot of programs that are potentially effective, but strengthening them is the key issue. And those that are more prevention as opposed to treatment are often the first to go because it is said, "Well, there isn't a problem there", and how do you know you are making a difference? And we would not put in place a program that did not have some strong scientific reason for it to be used; we have to evaluate that it works in a real-life setting, but the ones like the programs surrounding parenting have been tested in a real-life setting, which is one of their values.

Mr JOHN BARTLETT: You mentioned a licensing fee before. Why does the parenting program have a licensing fee?

Professor RAPHAEL: It is the developers in the program who are now working in the psychology department of the University of Queensland. It is through the Queensland university's system of trying to bring funds back in return for the work that is done. It is also international.

Mr JOHN BARTLETT: What would it cost?

Professor RAPHAEL: I cannot tell you that at the moment, but it is quite significant.

Mr JOHN BARTLETT: Is it paid for by NSW Health or does every individual parenting program—

Professor RAPHAEL: No. I would have to look into the new structures and find out—probably by NSW Health, but I cannot tell you that at the moment, I would have to check.

ACTING CHAIR: One of the things mentioned in the report is media training. You have made a couple of tantalising references to the media and its role. Could you tell us a little bit more about your views there?

Professor RAPHAEL: We certainly developed in the early stages of a suicide prevention strategy in 1999, or around that time, a kit and advice about the focus on the reporting of suicide. We do have a document about that but, more importantly, there were national initiatives as well. So across Australia there have been guidelines about the reporting of suicide and the reporting of mental illness in the media; they were evaluated and found not to have penetrated. Just as I have trouble getting dissemination out to the grassroots level, the media agencies who participated with the Australian Government in developing these resources had trouble getting them out to every journalist at the coalface.

So there has been some change, but not adequate, and a further development of that strategy, what is called Mind Frame, in the Commonwealth and the media professions of journalism, is happening now. I am not sure whether that will be released shortly or not. I think it is also that good news is not news, and that is a problem everybody has, it is not just mental health. It is not news that we have got good programs in place and we are building more strengths and someone got better; it is news that someone did not get access to care or that they died.

ACTING CHAIR: But do you think there is a real problem with insensitive media reporting of suicide, mental health issues, more broadly?

Professor RAPHAEL: I think that things have been better. I think there are many tragedies associated with premature death; it is a profound and complicated bereavement that occurs. People always look over and say, "If only I had done differently" or, "If only they had done differently". So in such circumstances it is not surprising people's tragic stories are of interest to the media. I think there is a limit to how often that should be replayed. In a way you become the victim as opposed to someone who has had a tragedy and moves on from it. I think that it is important how that is handled.

I have seen some people brought forward again and again to tell their story. In my opinion they have had a tragic experience and maybe the services did not handle it properly, but repeating that story again and again is not necessarily helpful to them in that very public way because they become identified as the victim rather than someone who has had a tragedy but had to move forward and has done so. That is one of the things. I think sometimes the media has slipped and started reporting the details of suicide death again. They generally know that they are not supposed to do that because of the risk of copycat suicides, particularly with rock idols for young people, for example. It is a tragedy that most people know someone who has killed themselves and it stays with you. If you have known the detail or found the person, the trauma of the loss and grief is very profound, and it is very hard to get over; it stays with you and it is a tragedy that people do live with, premature deaths and the deaths of children particularly.

Mr BARRY COLLIER: Professor, recently the son of one of my constituents committed suicide. That young person was an ambulance officer, and he committed suicide after a relationship breakdown. As he would have seen road trauma every day it seems extraordinary that he would have suicided.

Professor RAPHAEL: Yes.

Mr BARRY COLLIER: What role does relationship breakdown play in suicides in young people?

Professor RAPHAEL: It is often the precipitant in people who feel despair, rejection, hopelessness, and whose self-esteem and view of themselves may be quite vulnerable. The relationship, which had been supportive and nurturing and helped them through adversity has broken down and they are facing that loss without other support; they are vulnerable.

Mr BARRY COLLIER: In a boy-girl relationship?

Professor RAPHAEL: Yes, that is right.

Mr BARRY COLLIER: Is that a significant factor?

Professor RAPHAEL: It is, particularly as a precipitant.

Mr JOHN BARTLETT: It appears that hanging is the most-effective means of suicide once the decision is made. Other ways of committing suicide provide time for intervention.

Professor RAPHAEL: When I was a young doctor, many more people overdosed with barbiturates.

Mr JOHN BARTLETT: Has that changed?

Professor RAPHAEL: Yes. They were widely available and one could get a bottle full and tip it down the throat. When I was a medical student, one could get a handful of amphetamines from the chemist to help pass exams.

Mr JOHN BARTLETT: Hanging has become a more effective means?

Professor RAPHAEL: It has become the more frequent method of choice, and then carbon monoxide and other poisoning. Endeavours are under way to change that, and to have response systems which give an opportunity to stop cars producing carbon monoxide or to change the outlet so that a hose cannot be attached to it. There is a range of practical initiatives which come under the broad heading of "access to means", aimed at decreasing access to means of suicide. Hanging has always been a means of suicide. We have had some tragedies in in-patient units where we thought no person could possibly have a way of hanging oneself. That was the common way of killing oneself in such setting.

People have torn a bit of sheet or something of that kind in desperation. One woman hung herself using a hair band, a scrunchie, which I would not have thought possible. She

hooked it to a door handle. When one is desperate to take that step, hanging is more readily available. When we had less gun control, particularly in rural areas where guns were freely available, guns were a common form of suicide amongst young men. Young women have generally chosen overdoses, but that has been less effective. Of course, the gas was changed in response to data many years ago. Those means are less accessible, or less effective, and hanging is more effective. There is little chance of intervening once someone has made that decision.

Mr JOHN BARTLETT: There is more likely to be successful intervention in other options?

Professor RAPHAEL: Yes, it still depends on the determination of the person. Another thing with young people is that often they are angry; in their minds the finality of death may not be as readily true as it is to the more mature. They may know it intellectually, but they may never have seen the dead person and they may not understand. In their fantasy when they take an impulsive action, their wish is to be out of the circumstance, or to show someone what they have done. They may not even verbalise it, but in their hearts they have a fantasy that they will be there to see the effect. Intellectually they know that when they are dead, they are dead, but the reality of death and its permanency may not be in their minds when they take that action.

The Hon. MELINDA PAVEY: Only 30 per cent leave notes.

Professor RAPHAEL: Yes.

Mr BARRY COLLIER: With a person hanging themselves, it is much more traumatic for the person who finds them. Perhaps someone will find them in dead after having take a pill. Is there something in the mind of the person who chooses hanging to punish the person who finds them? Is there something in the mind that they want to make a big statement?

Professor RAPHAEL: I think it is more to do with the desperation they feel. It is much worse when people shoot themselves, particularly if they shoot themselves in the head, which they often do; that is very traumatic. It is extremely traumatic to find someone hanging.

Mr BARRY COLLIER: Is there something in their mind when they choose to do that?

Professor RAPHAEL: I do not think that is a major factor. I think it is the ease of access as a means and it has developed momentum of its own as a means.

Mr BARRY COLLIER: Following the Aboriginal deaths in custody inquiry virtually all holding places, police station cells and court cells, pending court appearance have been modified to reduce the possibility of hanging. Has that happened in the mental health facilities?

Professor RAPHAEL: We have done a range of audits, particularly audits of access to means within mental health units. New units are built with the aim of not providing those spots. We have required that area health services improve units and take away any hanging points wherever possible. Sometimes we could not imagine what might be a hanging point.

That audit will be repeated again regularly. The requirement is when a new unit is built that is to be taken into account.

Mr BARRY COLLIER: The desperation is such that a person will find a way, if there is a way?

Professor RAPHAEL: Not always. The fact that it is difficult may alter that and treatment may have time to work. It is a sad comment on the findings of the review committee that even in circumstances in which people are under relatively close observation in high level inpatient circumstances, that they have still found a way to kill themselves.

Ms SYLVIA HALE: Professor Raphael, you mentioned the prevalence of abuse of women during pregnancy. Does that occur only during pregnancy or is it symptomatic of an ongoing abusive relationship? Is there a definite correlation between that abuse and the impact on the child subsequently?

Professor RAPHAEL: Yes. There is not a lot of good data on the physical impact, whether the foetus is injured or damaged, but it certainly is part of a difficult psychological set for a woman who goes through a major experience such as the birth of a baby and then has to handle the fact that the partner, or someone else, hated her or hated the baby so much that they hit her and hurt her physically during the pregnancy. It is hard to imagine what it must feel like to have that experience. A number of studies have been conducted and the first one was carried out in Queensland at the Royal Women's Hospital, Brisbane. I could find the reference and forward it to you, but that would take some time. I get a new research person on Monday who could do it. There is much to suggest that it creates negativity, but I do not know about ongoing research on that. It is usually in the context of an abusive relationship.

Ms SYLVIA HALE: Is there any evidence of its effect upon the relationship between the mother and the child?

Professor RAPHAEL: Not that I know of. I will attempt to find out for you. It seems to me inevitable that it would have some impact, both on the wish to protect the child and the mother's concern, particularly if she is very anxious and uncertain and desperate to please her partner. She may feel afraid that she will be rejected and may be unable to attach to the baby.

ACTING CHAIR: It will be easier for you to provide answers to the questions you have taken on notice after you have read the transcript.

Professor RAPHAEL: Thank you, I have not made a list of all of them.

Ms VIRGINIA JUDGE: You have talked about some of the reasons for people committing suicide. In your report, what percentage of young people took their lives as a direct result of sexual abuse?

Professor RAPHAEL: I do not know the answer to that in terms of the Child Death Review Report. Usually it is not so much a direct immediate result, it is more a vulnerability

that contributes along the way. There is a range of studies that highlights the increased vulnerability to suicide behaviour in people who have been subject to abuse, domestic violence, and so forth. Mostly it has not been separated out, but it may be a strong risk factor. It is certainly not good for one's mental health generally, and certainly increases one's vulnerability to suicide-related thoughts and potential death by suicide.

The Hon. MELINDA PAVEY: Most of the statistics of girls having been sexually abused are in the report.

Professor RAPHAEL: Yes, it is an antecedent factor.

Ms VIRGINIA JUDGE: I know of two women who had been abused by their father and had tried to commit suicide.

Professor RAPHAEL: It has a very profound mental health impact. There was a time when it was difficult for Mental Health to accept the degree of that, the evidence is absolutely compelling from both prospective and cross-sectional studies.

Mr STEVE CANSDELL: Of the differing groups that commit suicide is there any data on bullying and of kids suiciding or attempting harm because of school bullying or intimidation?

Professor RAPHAEL: I know of no direct study, but I will look into it for you. It may take some weeks to find and provide to the Committee. The person who does my research is on leave to have a baby and the temporary replacement will arrive on Monday.

ACTING CHAIR: In some cases you may be able to advise the Committee Secretariat to the appropriate web site. The question on bullying is related to your earlier comment about the quiet and passive children who are often more at risk that not as notice as the aggressive ones. Those children are often victims of bullying.

Professor RAPHAEL: Indeed. They are picked on because they are quiet and passive. The "Mind Matters" initiative of the Australian Government for schools that was rolled out through principals, has an anti-bullying component.

ACTING CHAIR: Do you see benefits or scope for future collaborative efforts with the Commission on Children and Young People and/or the Child Death Review Team? Do you see a whole-of-government approach to those areas? Are there further suggestions you have on work that may be done?

Professor RAPHAEL: Yes. First, we are very keen to have an ongoing relationship with the Commission and are supportive of its advocacy role. I am very pleased that the Commission understands the importance of mental health. Second, there is whole lot of whole-of-government initiatives more broadly in response to the upper House inquiry report and the Government's response. The Senior Offices Group, which is looking at whole-of-government issues about some matters related to the Department of Community Services, will incorporate some of those issues. It is certainly very important.

A critical issue is that sometimes the needs of children and young people are seen as very broad and there is a failure to recognise that the specialist expertise of mental health

and specialist input is a critical component to strengthen the more broadly based approach and to back it up. From my point of view it is really important that the expertise is utilised to support the broad-based issues as well. Sometimes it sounds simple and people think it is simple to do it, but it is only simple if you know all the details. You need to know how to balance it and how back up can occur. We will never have enough child psychiatrists or child mental health people. It is critically important that the child agencies are familiar with what to do, to know when there is the need for specialist help, and when to get back up to discuss the cases.

ACTING CHAIR: Who takes the lead on that? Does there need to be a centre such as yours? Should it be organised through the Senior Offices Group or human services?

Professor RAPHAEL: Certainly some of it is organised through the Senior Offices Group and human services. It is a really good time now, with the response to the upper House inquiry, because it is required. The Senior Offices Group, chaired by Roger Wilkins, is oversighting the whole process. He gives high priority to it. There is a component of it that will look particularly at early intervention which, in my opinion, encompasses children and young people in that spectrum as well. So I think there is a momentum about this going forward now in a way that I am very happy with.

ACTING CHAIR: As long as you get some time outside all the meetings. You have already told us about five meetings this week.

Professor RAPHAEL: That is right. Also, I think, under the national mental health plan we hope for more support. It is true in some areas, particularly adolescence, the Australian Government is going to invest, mainly in general practitioners and support to general practitioners, about early intervention but it is really focusing on adolescents with a risk of depression and psychosis. We already have a program that will link too and I have approached the Commonwealth about how we can do this collaboratively as opposed to everyone going off in their own directions, which I think would be a big mistake. We could get more "bang for the buck", as they say, if we work together on this. We also have an Australian Government representative sitting on our suicide committee, so it is revising its strategy as well so we can all work together about the initiatives, should it put resources in. I also chair the national promotion prevention and early intervention working party under the national mental health plan. I will send you some of these documents so you can see how it is progressing there as well.

The Hon. MELINDA PAVEY: That was a good wrap up of where you want to go. There are three things you want to focus on over the next year, following on from this report?

Professor RAPHAEL: Yes.

The Hon. MELINDA PAVEY: Tangible outcomes in terms of co-operation between departments. How would you verbalise that?

Professor RAPHAEL: Three priorities?

The Hon. MELINDA PAVEY: Or four or five?

Professor RAPHAEL: Okay. I think strengthening our partnerships in the earlier stages of development of life. If we build something strong then, the foetus, the baby, the infants, the toddlers and their parents will have something to go forward with. Then I think having a set of strategies that builds on what the necessary developmental tasks and the mental health challenges throughout the life cycle and into adult life. We have some good programs, we probably need some more and we need to be able to resource them. I think it is this strengthening our capacity to handle the most seriously ill children. That serious illness is coming on at an earlier age and that is where we have a real gap and we do not have enough people. We have good leadership through people like Professor Nunn from the nexus unit at John Hunter Hospital and other workers in this field. Supporting some of the programs and extending them is a critical issue.

With respect to the sorts of deaths reported in the report, as you can see, these come from enduring difficulties, as was highlighted. Those enduring difficulties endure because we did not get in early enough. There are many solutions. We cannot do it all. There is Families First. I think strengthening the mental health components of all those along the way is critical. Unless you have an understanding of what the mental adversities that result from not doing something are, often you do not realise the priority for doing it. So, what we do not do will leave more problems for the future.

The Hon. MELINDA PAVEY: Coming back to that issue of drugs and Ritalin and ADHD, and your observation that children are going into severely mentally disabled areas much earlier in their lives, has there been enough research or do you think there needs to be another research program into this issue while general practitioners and professionals are overprescribing these?

Professor RAPHAEL: New South Wales, compared to some other States, has a good monitoring process—of course, you have to go through a request for it. One of the problems is that the symptoms of ADHD are not dissimilar to the symptoms of being traumatised by abuse. I was part of the committee that did the national survey. It did not deal with it adequately, despite my protests at the time, partly because there were great difficulties asking questions about abuse in a national survey because of the requirements to report it. So, it is difficult. There needs to be much better understanding of the pattern of symptoms in childhood and infancy and what their sources are, whether there is an abuse issue that is contributing to that clinical picture.

The Hon. MELINDA PAVEY: Or poor parenting skills?

Professor RAPHAEL: Yes, that is right, exactly. It may not be deliberate malevolent abuse; it might be lack of parenting skills, and there are things we can do about that with programs like PPP and a range of programs along the way that can support parents. Some parents are so disabled it may be difficult to support them and that is how the State and other agencies come in. Support care is critical. Another group that is vulnerable are children of parents who have a mental illness or a substance use problem, because of the parenting skills that may be impacted on by the illness or the substance use problem. How do we deal with children in that setting? We have a program—and I will leave you a copy of it here—which requires systematic documentation and looks at those issues and how we can better pick up, when a parent is admitted, if there is a dependent child in the family, where there

might need to be a program for the child. It is quite a big group and an important group that is not well developed but we have expertise that we are building on in that area.

An awful lot has to be done but I think if we try to do a bit at a time in the most vital areas first we have a chance of moving forward. We have put quite a lot of the building blocks in place. My anxiety is that we run the risk of some of these things getting lost. I suppose I am a strong advocate. I had my seventieth birthday about a month ago, and we all have to keep advocating. I cannot do it alone; it needs everybody to recognise what an important issue this is for all of our futures.

Ms SYLVIA HALE: There is a substantial group of children in the community who are physically or intellectually disabled. Is there any focus on their mental health needs? I imagine they would be acute, or they could be?

Professor RAPHAEL: Yes.

Ms SYLVIA HALE: I know major changes are under way in the type of programs they can access. Do you have the resources?

Professor RAPHAEL: At the moment we need to build those resources more. We have an outline of how a program might go forward. It would be fair to say that such children are accepted as clients of mental health services, not as non-clients. When I used to examine trainee psychiatrists for their exams they would not infrequently have a case to assess at that time. Nevertheless, the special needs are being better understood, and work such as that of Professor Stewart Einfeld at the University of New South Wales, who is a world expert in this field, has been innovative. It needs to feed much more into services and we are developing some programs but again getting the resources and processes to take that forward—

Ms SYLVIA HALE: I imagine it would be difficult to diagnose often because their mental health difficulties would be almost submerged beneath the physical?

Professor RAPHAEL: Yes, that is absolutely right. It takes a lot of skill and understanding in the educational and other assessments.

Ms SYLVIA HALE: There must also be increasing problems with the carers of those children and the impact that has?

Professor RAPHAEL: That is true, yes. I think the support for carers in a range of settings—in the national survey data it was quite clear that not only did the problem impact on the child but it impacted also on the family when there was a significant mental health problem, let alone a disability as well. There has been quite significant comment on this from Australian Carers New South Wales on the issues and lack of support for the people who care—frequently women. But men also care and the whole issue of how you do that in a supportive way which does not leave you as a mental health casuality as well is a critical issue.

Ms SYLVIA HALE: I understand it is compounded by the fact that a lot of carers are women who come from, say, non-English-speaking groups who feel that somehow it is a

family disgrace that must be hidden from view, yet their ageing means they are less and less able to provide that care?

Professor RAPHAEL: Yes, I think that is a big social issue and I do not have the answer to it. We have a carers program that we fund through the Centre for Mental Health to look at ways to support carers, and a report will be coming out of that either in the latter part of this year or early next year.

ACTING CHAIR: That relates to carers of people with a mental health problem or carers more broadly?

Professor RAPHAEL: It does, but it is also looking at a model more broadly because all carers have mental health issues. There are specific issues for carers of people with mental health problems but there are similar things that affect all carers. First of all, it is the behavioural disturbance whether the person has a mental health problem or not, the amount of time you have in care and respite, and understanding and being able to communicate with the health care providers about the person's disability. Many reports from carers say they were treated like second-class citizens or they did not know, what to do and certainly that happens a lot with mental health. Family members have been putting submissions in about a review of the Mental Health Act, and a carers paper is one of the review papers that has come out of that.

The Hon. MELINDA PAVEY: As a matter of procedure so I get an understanding of how it is reported, if the suicide happens in New South Wales, obviously the police go to the scene. Do you get a report of every incident or does someone within the Department of Health receive it?

Professor RAPHAEL: We had a funded program, which we do not have now, where we would get the police reports. We frequently get criticised by a range of groups for not reporting on the suicides related to mental health clients, but it is not a suicide until the coroner has determined it is a suicide. We can provide reports and we will be providing reports on possible suicide deaths of people who are clients of mental health services. We try to strengthen our understanding of that through the police reports of death, which were very good sources of information, to get a more up-to-date report. When we report on a suicide, statistics alluded to in the comments in this document, the suicide statistics come from our bit of the national suicide database. We contribute to try to find out about that and that goes into our sentinel event review committee but it does not identify whether somebody has been a client of mental health services or not. So, there is quite a strong issue for us about knowing the circumstances.

That is one of the reasons we set up a sentinel event review committee, to try to look at all the possible suicide deaths reported to the Department of Health, who were people known to mental health services, either as inpatients or subsequent to their discharge, and to explore through the records and every other way the potential factors—did the services fail or did they do everything they could, and what can we do to improve things? The first report was called "Tracking Tragedy" and it made a number of recommendations, and the Government's response to those is well under way but the formal response should be released soon. The second report will come out early next year. It looks again at suicide after discharge and

homicides, and will provide recommendations as to how we can do better. Some things we can do but some things are beyond our control.

The Hon. MELINDA PAVEY: So the coronial report would come out two or three weeks after?

Professor RAPHAEL: The coronial report may be quite a long time later. All the coronial recommendations come to us. If they have anything to do with mental health the coroner writes. I meet with the coroner on a regular basis and we talk through issues. The coronial recommendations vary. Sometimes there are things we can do; sometimes they are things beyond the scope of the mental health service in terms of privacy and other matters. But we respond always and we have a database on what we have done and what we were not able to do with respect to coronial recommendations, and the sentinel event review committee also considers those. That is the committee chaired by Professor Peter Baume, a ministerial committee.

Ms VIRGINIA JUDGE: Picking up on the point that Ms Pavey just brought up, recently I held a mental health forum in my electorate. One of the recommendations from the report was that we should look at our national system of reporting, not just for suicide but also for attempted suicide. From your experience, do you think that would be a useful thing to happen?

Professor RAPHAEL: There are many different ways in which attempted suicides are coded. Sometimes they are coded as a poisoning, sometimes they are coded as an injury, and sometimes they are coded as suicide so it would have to be a suicide attempt.

Ms VIRGINIA JUDGE: Right.

Professor RAPHAEL: I could forward you a paper one of my staff did some years ago showing the relationship between death by suicide and the number of suicide attempts. I think all data is helpful, so I would not speak against data. I think it would take quite a lot of collaboration to bring it through the Australian Institute of Health and Welfare to get to an agreed database about that.

Ms VIRGINIA JUDGE: At least it would give you some benchmark to know whether our figures are going up or down. We can do it with diseases. I just wonder whether that would be useful. You could look at it state by state.

Professor RAPHAEL: Yes, we certainly get the suicide data state by state. That will probably come out just before Christmas.

Ms VIRGINIA JUDGE: That is already happening?

Professor RAPHAEL: Suicide deaths, yes, that already happens. It is the attempted suicide that is complex because of the different ways and the health care systems between the States vary so much that to get agreement on something is quite difficult in terms of the formal legislation of States and their health care systems being somewhat different. So the

suicide deaths, yes, there is a national process for that and we can send you that data when it comes out.

ACTING CHAIR: In terms of attempted suicide and risk taking, there are privacy issues.

Professor RAPHAEL: Exactly.

ACTING CHAIR: And issues of sensitivity, I suppose.

Professor RAPHAEL: Yes, and interpretation of the data. Was it a moment of anger or what was the intent behind it? Was it a suicide intent? It is because the data is coded in different ways, if someone does an overdose or tries to poison themselves they might come in with poisoning. And we have some quite good data from the Mater in Newcastle where Dr Greg Carter has done considerable work looking at the toxicology and patterns in that particular group of people; then there is injury data that comes from the injury production people. So there are many ways in which attempted suicides are coded, but it is not all put together. There is no variation in the way in which it is coded everywhere.

ACTING CHAIR: It also strikes me that it would be much harder to relate much of the data you have talked about to children and young people.

Professor RAPHAEL: Yes, it would because the numbers are so small.

ACTING CHAIR: And the years that have elapsed?

Professor RAPHAEL: Yes.

ACTING CHAIR: Very young children perhaps rarely attempt suicide.

Professor RAPHAEL: Yes.

ACTING CHAIR: You are dealing with a very small number of years.

Professor RAPHAEL: That is correct.

ACTING CHAIR: You can generalise from patterns.

Professor RAPHAEL: Yes, and it is hard to make assumptions about any differences, say, between the States because the small numbers are not statistically significant.

ACTING CHAIR: Thank you very much for coming and perhaps even more for the enormous number of things you have offered to help us with. Once we have the transcript that will identify them for us.

Professor RAPHAEL: Yes, it would be good if you highlight them when you see it, so thank you.

ACTING CHAIR: In many cases you probably need only point us towards the publication.

Professor RAPHAEL: Yes, we could get the reference for you. It must take a bit of searching, but I will get my person on to it.

(The witness withdrew.)

(The Committee adjourned at 12.05 p.m.)

Chapter Six - Responses to questions taken on notice (hearing 25/11/2004)

Responses by Professor Beverley Raphael to questions taken on notice at the hearing on Thursday 25 November 2004

Data related questions
Responses to data related Questions Taken on Notice located at transcript page numbers 4,10,15,16, 26 are to be found in Enclosure 1*.

Link between cannabis use and development of mental health conditions (page 6)
Research paper is enclosed. This paper due for publication in May 2005.

Specific programs or research for children in care of the State with mental health problems (page 7)
No information has been located on mental health programs or research that specifically address the needs of children in care of the State or those who have left care.

Programs for handling HSC stress (pages 8-9)
This question has been referred to the Department of Education and Training for response. The information is not available to report to the Committee at this time.

Support for families after a suicide (page 12)
1. Contact for National Association for Loss and Grief (NSW):
   State President: Julie Dunsmore
   Telephone: 2992 6926
   Email: info@nalag.org.au
2. *Care and Support pack for families and friends bereaved by suicide* (copy enclosed)
3. *Family Help Kit* (copy enclosed) — referred to on pages 12 and 17.

Family awareness of how/where to seek support for mentally ill child (page 17)
Copy of the Child and Adolescent Component of the National Survey of Mental Health and Well-being — *Mental Health of Young People in Australia,* referred to in response, is enclosed. The issues are reported in Chapter 6, dealing with service utilisation*.

Question concerning licensing fee for Parenting Program (page 19)
Professor Raphael indicated that she would investigate the payment arrangements for the parenting program referred to in the discussions.
NSW Health has paid the licensing fee for the program. Currently NSW Health is investigating evidence based parenting programs for use by NSW Area Health Services over the next three years.

* Available from the Committee Secretariat

Abusive relationships during pregnancy and subsequent impact on the child (pages 21 and 22)
Relevant references to studies are enclosed*.

Data on school bullying as a risk factor for suicide or attempted suicide in children (page 22)
No direct studies have been located on this matter.

National Promotion Prevention and Early Intervention Documents (page 23)
Recent national reports still in draft and not available at this time.

* Available from the Committee Secretariat

APPENDIX 1: COMMITTEE MINUTES

Minutes of Proceedings of the Committee on Children and Young People
Tuesday 23 November 2004 at 2.00pm
Room 814/815, Parliament House

Members Present
Mrs Perry (Chair), Mr Bartlett, Ms Burnswoods (Vice-Chair), Mr Cansdell, Mr Catanzariti, Mr Collier, Ms Griffin, Ms Hale, Ms Hopwood, Ms Judge and Ms Pavey.

Also in Attendance
Helen Minnican, Hilary Parker, Pru Sheaves

PUBLIC HEARINGS

.....

3. REVIEW OF THE CHILD DEATH REVIEW TEAM REPORT *SUICIDE AND RISK-TAKING DEATHS OF CHILDREN AND YOUNG PEOPLE*
The hearing resumed at 3.45pm.

Ms Gillian Elizabeth Calvert, Commissioner, NSW Commission for Children and Young People, on former affirmation.

The Committee questioned the Commissioner.

At the conclusion of the questioning Ms Calvert agreed to table any questions on notice on the Reviews of the Child Death Review Team Reports that remained unanswered. The Chair then thanked the witness and the witness withdrew. The Committee adjourned the hearing at 4.09pm.

DELIBERATIVE MEETING
The deliberative meeting commenced at 4.10pm.

The Chair addressed the Committee about the next day of hearing for the Review of the *Suicide Report*, at which Professor Beverley Raphael, Director, NSW Centre for Mental Health, would appear as witness.

Resolved on the motion of Ms Judge, seconded by Ms Griffin, that the Committee forward the uncorrected transcript of the day's hearing on the Review of Child Death Review Team Report *Suicide and Risk-Taking Deaths of Children and Young People* to Professor Raphael in preparation for her appearance before the Committee on 25 November 2004.

As a consequence of the Chair's announcement that Dr Michael Dudley, Chairperson, Suicide Prevention Australia, had been unable to attend as a witness for the Review of the *Suicide and Risk-taking Deaths Report* at 4.00pm, the Committee agreed to discuss the merit of re-scheduling Dr Dudley at the conclusion of Professor Raphael's evidence on Thursday 25 November.

The Committee adjourned at 4.13pm until 10.00am, 25 November 2004.

Minutes of Proceedings of the Committee on Children and Young People
Thursday 25 November 2004 at 10.00am
Room 814/815, Parliament House

Members Present
Ms Burnswoods (Acting Chair), Mr Bartlett, Mr Cansdell, Mr Catanzariti, Mr Collier, Ms Griffin, Ms Hale, Ms Judge and Ms Pavey.

Apologies
Ms Hopwood, Mrs Perry.

Also in Attendance
Helen Minnican, Hilary Parker, Pru Sheaves

PUBLIC HEARING
REVIEW OF THE CHILD DEATH REVIEW TEAM REPORT *SUICIDE AND RISK-TAKING DEATHS OF CHILDREN AND YOUNG PEOPLE*
The hearing commenced at 10.05am.

Professor Beverley Raphael, Director, New South Wales Centre for Mental Health, took the oath. Professor Raphael made an opening statement. The Acting Chair questioned Professor Raphael, followed by other Members of the Committee.

Professor Raphael tabled the following items for the information of Committee Members:

- brochures: *Supporting children after suicide*; *NSW School-Link initiative*; and *Bereavement Care* (and Bereavement Care CD);
- information on suicide risk assessment and management including *Training Manual: Introduction to Clinical Aspects of Suicide Prevention for Young People* and *Framework for Suicide Risk Assessment and Management for NSW Health Staff.*

Questioning concluded, the Acting Chair thanked the witness and the witness withdrew. The committee adjourned the hearing at 12.05pm.

DELIBERATIVE MEETING
The deliberative meeting commenced at 12.05pm.

Resolved on the motion of Ms Griffin, seconded by Ms Judge, that the Committee decide whether to re-schedule the appearance of Dr Michael Dudley, Chairperson, Suicide Prevention Australia, at the Committee's next deliberative meeting.

.....

Minutes of Proceedings of the Committee on Children and Young People
Thursday 3 March 2005 at 1.15pm
Room 1108, Parliament House

Members Present
Ms Perry (Chair), Ms Burnswoods (Vice-Chair), Mr Cansdell, Mr Bartlett, Ms Griffin, Ms Judge, Ms Hopwood and Ms Pavey.

Apologies
Mr Collier

Also in Attendance
Helen Minnican, Pru Sheaves, Kylie Rudd

The meeting commenced at 1.20pm.

.....

3. Current Inquiries

.....

(b) Review of the report on *Suicide and risk-taking deaths of children and young people*

The Committee considered whether or not to reschedule a public hearing with Dr Michael Dudley to give evidence in relation to the review of this report by the Child Death Review Team.

Resolved on the motion of Ms Burnswoods, seconded Ms Pavey, that the transcript of evidence from Ms Gillian Calvert and Dr Beverly Raphael be forwarded to Dr Dudley for his comment. Dr Dudley was to be provided with a 4-6 week turnaround time for a written comment, and advised that if a comment was not received within this period, the Committee would proceed to finalise and table the report.

.....