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Joint Committee on Children and Young People

Report 5/56 – October 2018

Prevention of Youth Suicide in New South Wales



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The motto of the coat of arms for the state of New South Wales is “Orta recens quam pura nites”. It is written in Latin and means “newly risen, how brightly you shine”.

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Membership

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Chair's Foreword

Suicide is a leading cause of death for our children and young people. Sadly, in 2017, the number and rate of children under 18 who died by suicide in New South Wales was the highest in 20 years.

The loss of a young person can seem particularly devastating – our young people should have their whole lives ahead of them. When a young person takes their own life, the impact can be felt across families, friends, schools and entire communities.

There is no doubt that there is a need for suicide prevention services and support which focuses on the whole population, as suicide affects all age groups. However, the focus of this inquiry has been to specifically look at the approaches to preventing the suicide of children and young people in New South Wales.

During this inquiry, the Committee heard from people with lived experience of suicide, including the parents and families of young people who have died by suicide. We met some of these families at a private roundtable session in Singleton. We also read submissions from bereaved parents, as well as young people with lived experience. They gave us a better understanding of the very real human cost of youth suicide. We thank them for sharing their stories.

Suicide prevention is an area where many organisations and people are doing great work, supported by the New South Wales and Commonwealth Governments. The most prominent example of this may be the LifeSpan trials now taking place across Australia. LifeSpan embodies a 'systems based' approach to suicide prevention, recognising that it works best when tailored to the evidence and the unique needs of each community. Four LifeSpan trials are being undertaken in New South Wales over the next few years: in Newcastle, Illawarra Shoalhaven, Murrumbidgee and the Central Coast. The results of these trials should provide further valuable evidence of what works and where further support is needed.

The recommendations in this report support the significant work that is underway, and also aim to address more immediate concerns by building upon the emerging knowledge base. I will outline some of these recommendations below.

Given the complicated web of suicide prevention services that exists at the local, state and federal levels, the Committee has made several recommendations aimed at improving governance and coordination and, in particular, assisting young people and their families to find the services they need.

Suicide prevention strategies should be based on evidence, and so the Committee has made a number of recommendations directed at improving the evidence base for some groups at higher risk of youth suicide. This includes looking at what more could be done to reach young men, who often don't seek help, and what suicide prevention programs work best for LGBTI young people. Further research will help answer some of these questions.

There is a high risk of suicide for children and young people who have a child protection history or who are Aboriginal or Torres Strait Islander. This is why the Committee has made several recommendations aimed at reducing the unacceptably high rates of suicide within these groups.

Children and young people can be reluctant to seek help, or may not know where to start. Of those young people from NSW who did seek help last year, only 58% were successful in contacting Kids Helpline. For this reason, the Committee has recommended that the Government consider further funding to youth-focused services like Kids Helpline to help ensure that more contacts are answered. Encouragingly, the Commonwealth Government has recently announced that eheadspace, an online youth counselling service, will receive an extra \$12.8 million.

To solve a problem, you have to first understand it. For this reason, the Committee has recommended improvements to the way data on suicide and self-harm is collected in New South Wales, including the creation of a suicide register and mortality review team. The Committee hopes this will provide a clearer picture of youth suicide and identify areas of emerging risk.

Social media has both a positive and negative role to play in youth suicide. The constantly evolving nature of social media can make it difficult to understand its true impact on youth suicide and self-harm. While it can be used to promote help-seeking and link young people in crisis to support, it may also expose young people to trauma or otherwise increase their distress. As this is a new area, the Committee sees benefit in further research on the relationship between social media and youth suicide.

Despite its complicated nature, it is clear that technology has and will continue to have an important role in overcoming some of the barriers that prevent young people seeking help. In addition to improving post-discharge care to ensure that children and young people receive adequate follow-up after visiting hospital, the Committee has recommended that the government investigate opportunities to use technology to provide clinical support to children and young people in regional, rural and remote areas who may find it difficult to access a face-to-face service.

Schools, TAFEs and universities present unique opportunities to reach children and young people. Overall, there is much positive work being done to promote mental health and wellbeing among high school students. The major gap appears to be in TAFEs and universities. The transition from high school to tertiary education is a time of elevated risk for young people, and so the Committee has recommended that the NSW Government work with the tertiary education sector to implement suicide prevention activities.

While there is great work being done to prevent youth suicide, there is more to be done. I hope that the Committee's recommendations will go some way to reducing the number of children and young people who take their own lives or consider taking their own lives.

In the week leading up to the Committee's report, a number of high-profile announcements relating to suicide prevention were made. We welcome the Commonwealth Government's commitment to providing further funding to suicide prevention research, with a focus on youth and Indigenous mental health, and the extra resources which will be provided to Headspace, including their online youth counselling arm. The Committee was also encouraged to see the New South Wales Government release the *Strategic Framework for Suicide Prevention in NSW 2018 - 2023*, and \$90 million to support implementation of the strategy.

While these recent announcements may have some bearing on the recommendations made in this report, they generally respond to areas of need already identified by the Committee. As

Chair of the Committee I welcome these developments, and am pleased to see that there is a shared commitment to improving suicide prevention services across Australia.

Again, I thank all those who participated in this inquiry, for sharing their stories or their expertise. I would like to particularly thank The Hon. Catherine Cusack MLC for her advocacy and support for this inquiry during her time on the Committee. Thank you also to my fellow Committee members for their dedication to this inquiry, and their ongoing commitment to improving the lives of children and young people in our State. I would also like to express my, and the Committee's, thanks to our Secretariat for their helpful and considered guidance throughout this inquiry.

A handwritten signature in blue ink, appearing to read 'Melanie Gibbons', with a stylized flourish at the end.

Melanie Gibbons MP
Chair

Executive summary

On 22 June 2017, the Committee resolved to conduct an inquiry into the current approaches aimed at preventing youth suicide in children and young people, with particular focus on:

- any gaps in the coordination and integration of suicide prevention activities and programs across all levels of government;
- governance arrangements and accountabilities for suicide prevention;
- the provision of services in local communities, particularly in regional and rural areas;
- the provision of services for vulnerable and at-risk groups;
- data collection about the incidence of youth suicide and suicide attempts;
- the provision of information and training to service providers; and
- approaches taken by primary and secondary schools.

For the inquiry, the Committee adopted the definition of 'young person' in the *Advocate for Children and Young People Act 2014*, which is a person who is 12 years of age or above but under 25 years of age.

It was important to the Committee to seek information from a range of stakeholders including those with lived experience of suicide. The Committee received a number of submissions from organisations and individuals and held a number of hearings, in both Sydney and Singleton. As part of its Singleton visit, the Committee held a private round-table session with people with lived experience of suicide.

Chapter One outlines the current governance arrangements for youth suicide in New South Wales and the gaps in policy and governance observed by inquiry participants. It notes current initiatives operating at both a national and state level, such as the recent endorsement of the Fifth National Mental Health and Suicide Prevention Plan; the number of Lifespan trial sites; and the recently announced Strategic Framework for Suicide Prevention in NSW 2018-2023. These are encouraging initiatives that provide opportunities for greater coordination between governments and non-government organisations. The Committee makes recommendations to ensure that the Strategic Framework for Suicide Prevention in NSW 2018-2023 aligns with what is operating nationally.

To assist with better coordination, the Committee recommends that current initiatives, such as the Lifespan trial sites, are monitored and evaluated and the outcomes from the evaluation are shared with other governments.

A further topic explored in this Chapter is the need for a youth specific policy response to suicide prevention. Inquiry participants noted that a youth specific response is important due to the high rates of self-harm in children and young people, the onset of mental ill-health during this period of life, and that youth suicide is more likely to be part of a cluster than adult suicide. To

this end, the Committee recommends that a youth specific suicide prevention plan is developed in consultation with children and young people.

The Chapter further comments on the range of programs, organisations and services available in this area and the difficulties associated with navigating the system. To assist a young person to find what is available where they live or choose a program that may assist them, the Committee recommends that an online directory of suicide prevention services be developed that is designed specifically for children and young people.

Chapter Two focuses on groups of children and young people who, unfortunately, are at greater risk of suicide. The Committee makes a number of specific recommendations targeted at these groups.

The groups of vulnerable children discussed in the Chapter include: children and young people with a child protection history; those of Aboriginal and Torres Strait Islander status; young men; children and young people living in regional, rural and remote areas; and LGBTI young people.

Concerning children and young people with a child protection history, as this group often have complex needs involving multiple agencies, the Committee recommends that strategies around interagency coordination and communication are developed, implemented and monitored to reduce the high rate of suicide.

The Committee notes the continued overrepresentation of Aboriginal and Torres Strait Islander children and young people dying by suicide and considers there needs to be an ongoing specific commitment to this vulnerable group. The Committee recommends that an Aboriginal and Torres Strait Islander specific youth suicide prevention plan for New South Wales be developed.

The Committee also heard that young men are consistently overrepresented in suicide deaths of children and young people. Inquiry participants discussed the reluctance of young men to seek help when they require it and the need for programs and services to be suited for young men. The Committee makes recommendations aimed at providing support for programs in schools and the broader community that are designed to promote help seeking behaviour in young men; and also recommends that support be provided to research and consult with young men on what mental health services and programs they would access.

The Committee discusses the challenges facing children and young people living in regional, rural and remote areas including distance, cost and the lack of services available. The Committee recommends that the NSW Government sets a minimum standard in terms of the provision of mental health services in regional, rural and remote New South Wales and funds the delivery of those services. The Committee further recommends that to assist with alleviating cost and distance, the NSW Government assist regional, rural and remote communities to subsidise or eliminate travel costs for children and young people travelling to and from approved health services.

The Committee also focuses on LGBTI children and young people and the experiences of this group accessing non-discriminatory and sensitive clinical support. The Committee recommends that further research should be conducted on effective programs and services for LGBTI young people.

The Committee also recommends that NSW Health undertakes and publishes a comprehensive international literature search of peer review research into what have been evaluated as successful suicide prevention programs for children and young people.

Chapter Three examines the barriers that children and young people experience in trying to access clinical services that may assist in preventing suicide. The Committee heard that young people found it difficult to access services for several reasons including: a lack of services; distance; long waiting lists; cost and stigma.

The Chapter explores using technology, such as web-based services, telepsychology and videopsychology, to address some of the barriers experienced by children and young people. While not appropriate in all cases, the provision of clinical support through technology may overcome some of the main barriers children and young people face. The Committee makes recommendations to encourage the use of technology and also expand services to assist health professionals in emergency departments. The Committee also recommends funding to technology-based services to improve the response rate to contacts made from children and young people.

The Committee also discusses the important issue of continuity of care after a child or young person has been discharged from hospital following a suicide attempt. The Committee learned that the period following a suicide attempt is a high risk period and inquiry participants highlighted the lack of post-discharge care as an area of concern.

The Committee notes there is a performance indicator in place to monitor the follow-up care provided to a child or young person, and considers there should be little reason why this indicator should not be consistently met. On this issue, the Committee recommends that NSW Health prioritise strategies to improve post discharge care, especially for children and young people who show reluctance to receiving care.

A further issue discussed in this Chapter is the need for suicide prevention strategies to be co-designed with young people.

Chapter Four focuses on the data collected on youth suicide and self-harm. The Committee notes that reliable and timely data helps government and non-government organisations to make informed decisions about youth suicide prevention.

The Committee notes the challenges with current data collection, namely that it is collected inconsistently, is not shared between organisations and is often not publicly available. In addition, data on suicide, suicide attempts and self-harm is not timely.

The Committee recommends that a suicide register is established in New South Wales to assist with addressing these challenges. The Committee also recommends that the NSW Government consider establishing a suicide mortality review team be established to conduct detailed reviews and make recommendations to government.

The Chapter further explores the importance of data collection of self-harm and suicide attempts and the need for the collection of this data to be improved. The Committee notes there are current methods being explored to collect this data through the Lifespan trials and also a hospital-based linked sentinel system, and recommends that a multicentre sentinel system be established.

Chapter Five discusses the importance of talking about suicide appropriately and sensitively. It also explores the complicated role social media plays in this area. The Committee heard evidence that social media is increasingly becoming a platform where children and young people can have productive conversations about mental health. However, the Committee heard evidence that the role of social media is complex and that more research was needed on this emerging area. To that end, the Committee recommends that further research be conducted on the impact of social media on youth suicide.

The Committee also discusses the importance of gatekeepers as a valuable tool in suicide prevention. Gatekeepers are people who come into contact with at-risk individuals and may be in a position to influence that individual's decision to access help. Gatekeepers can include a range of people such as friends, parents, teachers, sports coaches or GPs.

The Committee notes that gatekeeper training is one of the nine strategies being implemented as part of the LifeSpan trial sites. However, given the favourable evidence on the value of gatekeepers the Committee recommends that gatekeeper training is expanded beyond the LifeSpan trial sites. The Committee also recommends that gatekeeper training be compulsory for all child protection workers and foster carers.

A final area the Chapter explores is mental health education in schools. Schools provide a unique opportunity to engage with a large number of children and young people about mental health and wellbeing. The Committee received extensive evidence on the current programs and initiatives the Department of Education has implemented and was encouraged by the Department's ongoing efforts. However, the Committee identifies some gaps in the provision of suicide prevention activities and services in educational settings which it recommends the NSW Government address.

The most significant gap appears to be in tertiary education where the transition to life after high school seems to be a time of heightened vulnerability. The Committee recommends that the NSW Government work with the tertiary education sector to implement suicide prevention activities in this sector. Secondly, the Committee heard troubling evidence that thoughts of suicide are occurring in children as young as 7 and 8 and that there should be more prevention programs targeted at primary school children. The Committee recommends that a review be undertaken to assess the adequacy and efficacy of the current suicide prevention and wellbeing activities being provided to primary school students.

The Committee further notes the increase in the number of funded school counsellor positions across New South Wales and the difficulties with recruiting for these positions. The Committee recommends that the NSW Government prioritise filling these positions.

Recommendations

Chapter One – Governance and coordination

Recommendation 1 _____ 9

The Committee recommends that the Mental Health Commission of New South Wales ensures that the Strategic Framework for Suicide Prevention in NSW 2018-2023 aligns with the Fifth National Mental Health and Suicide Prevention Plan.

Recommendation 2 _____ 9

The Committee recommends that the Mental Health Commission of New South Wales ensures that the Strategic Framework for Suicide Prevention in NSW 2018-2023 supports and incorporates community led suicide prevention activities.

Recommendation 3 _____ 11

The Committee recommends that the NSW Government develop a youth specific suicide prevention plan developed in consultation with children and young people.

Recommendation 4 _____ 15

The Committee recommends that the NSW Government monitor and evaluate the progress of the LifeSpan trial sites in New South Wales and share outcomes with other governments in relation to the model's effectiveness and appropriateness for children and young people in regional, rural and remote areas and metropolitan areas.

Recommendation 5 _____ 17

The Committee recommends that the NSW Government develop an online directory of programs and services specifically targeted for children and young people to access. The directory should be co-designed by children and young people, and map programs available by geolocation and local health district.

Chapter Two – Vulnerable and at-risk children and young people

Recommendation 6 _____ 20

The Committee recommends that the NSW Government develop, implement and monitor strategies around interagency co-ordination and communication to reduce the high rate of children and young people with a child protection history dying by suicide.

Recommendation 7 _____ 24

The Committee recommends that the NSW Government develop an Aboriginal and Torres Strait Islander specific youth suicide prevention plan for New South Wales consistent with the findings of the ATSIPEP study.

Recommendation 8 _____ 26

The Committee recommends that the NSW Government continues to support programs in schools, and increase its support for programs in the broader community, that are designed to promote help seeking behaviour and improve mental health awareness in young men.

Recommendation 9 _____ 26

The Committee recommends that the NSW Government provide support to research and consult with young men on what mental health services and programs they would access.

Recommendation 10 _____ 29

The Committee recommends that the NSW Government set a minimum standard for the provision of and access to mental health services in regional, rural and remote New South Wales, and fund the delivery of those services.

Recommendation 11 _____ 29

The Committee recommends that the NSW Government assist regional, rural and remote communities to build partnerships between local councils, health providers, community groups and transport providers to subsidise or eliminate travel costs for children and young people travelling to or from an approved health service.

Recommendation 12 _____ 32

The Committee recommends that the NSW Government make specific reference to vulnerable and at risk children and young people in any youth suicide prevention plan and consults with vulnerable and at risk children and young people in its development.

Recommendation 13 _____ 32

The Committee recommends that the NSW Government support research into suicide prevention programs for LGBTI young people.

Recommendation 14 _____ 32

The Committee recommends that the NSW Government makes a request to NSW Health to undertake and publish a comprehensive international literature search of peer review research into what have been evaluated as the most successful suicide prevention programs for children and young people.

Chapter Three – Accessing services

Recommendation 15 _____ 40

The Committee recommends that NSW Health prioritises strategies to improve post discharge care for children and young people, especially children and young people who show reluctance to receiving care.

Recommendation 16 _____ 43

The Committee recommends that the NSW Government investigate opportunities to use technology, such as telepsychology, videopsychology and web-based programs, to provide clinical support to children and young people in regional, rural and remote areas who may find it difficult to access a face-to-face service.

Recommendation 17 _____ 44

The Committee recommends that the NSW Government consider expanding telepsychiatry services such as the Northern Mental Health Emergency Care – Rural Access Program to more emergency departments across the State, particularly in regional, rural and remote areas.

Recommendation 18 _____ 46

The Committee recommends that the NSW Government consider providing funding to youth-focused services like Kids Helpline, ReachOut and eheadspace to improve the response rate to contacts from children and young people in New South Wales.

Chapter Four – Improving data collection

Recommendation 19 _____ 62

The Committee recommends that the NSW Government establish a suicide register in New South Wales.

Recommendation 20 _____ 62

The Committee recommends that the NSW Government consider establishing a suicide mortality review team to review suicide deaths in New South Wales.

Recommendation 21 _____ 65

The Committee recommends that the NSW Government establish a multicentre sentinel system to collect data on self-harm and suicide attempts.

Chapter Five – Awareness, training and education

Recommendation 22 _____ 71

The Committee recommends that the NSW Government support research into the impact of social media on youth suicide.

Recommendation 23 _____ 74

The Committee recommends that the NSW Government expand gatekeeper training beyond the LifeSpan trial sites targeting persons across New South Wales who are likely to come into regular contact with children and young people.

Recommendation 24 _____ 75

The Committee recommends that the NSW Government make training on youth suicide prevention, including gatekeeper training, compulsory for all child protection workers and foster carers.

Recommendation 25 _____ 81

The Committee recommends that the NSW Government work with the tertiary education sector to implement suicide prevention activities, including postvention, in universities and TAFEs in New South Wales.

Recommendation 26 _____ 81

The Committee recommends that the NSW Government reviews the adequacy and efficacy of the suicide prevention, postvention and mental health and wellbeing programs currently provided to primary school students in New South Wales.

Recommendation 27 _____ 81

The Committee recommends that the NSW Government prioritise filling school counsellor positions, particularly in regional, rural and remote areas.

Chapter One – Governance and coordination

- 1.1 This chapter outlines the current governance arrangements for youth suicide prevention in New South Wales and highlights gaps observed by inquiry participants in policy, governance and the coordination of suicide prevention activities for children and young people.

Current policy and governance framework

- 1.2 For several years governments across all levels have developed suicide prevention policies and strategies. Currently there a number of initiatives operating across all levels of government.
- 1.3 There are also a range of government and non-government agencies that have a specific role relevant to suicide prevention for children and young people.

National

Fifth National Mental Health and Suicide Prevention Plan

- 1.4 In August 2017, the Council of Australian Governments Health Council (COAG Health Council) endorsed the Fifth National Mental Health and Suicide Prevention Plan (the Fifth Plan). The Fifth Plan lists suicide prevention as a priority area and commits governments to adopt a systems based approach to suicide prevention. Three actions, specific to suicide prevention, have been assigned to governments including:
- the establishment of a Suicide Prevention Subcommittee that will report to the Mental Health Drug and Alcohol Principal Committee (MHDAPC) on priorities for planning and investment;
 - the development of a National Suicide Prevention Implementation Strategy which prioritises providing consistent and timely follow-up care for people who have attempted suicide, improving cultural safety across services, improving relationships between providers, and improving data collection; and
 - supporting the Primary Health Networks (PHNs) and Local Hospital Networks (LHNs) to develop whole-of-community approaches to suicide prevention.
- 1.5 The National Mental Health Commission (NMHC) is preparing an annual report on the progress of the priority areas with the first report to be completed in October 2018.¹

National Suicide Prevention Strategy

- 1.6 The National Suicide Prevention Strategy (NSPS) commenced in 2000 with a renewed strategy announced in November 2015. The renewed NSPS responds to

¹ See: <http://www.mentalhealthcommission.gov.au/our-reports/fifth-national-mental-health-and-suicide-prevention-plan.aspx> viewed on 14 August 2018

the 2014 report of the NMHC into mental health programs² and has four components of which the Fifth Plan is one.

- 1.7 The NMHC recommended that 12 regions be established across Australia for the introduction of sustainable, comprehensive, whole-of-community approaches to suicide prevention.³
- 1.8 In 2016 the Commonwealth Government announced that under the NSPS, 12 Suicide Prevention Trials (NSPTs) will be established throughout Australia. Managed by the PHNs, the NSPTs initially covered a three year period from 2016 to 2019. In May 2018, the Commonwealth Government announced an extension of funding up to 2020.
- 1.9 Two NSPT sites have been established in New South Wales in Western New South Wales and the North Coast. The PHNs are working with the Black Dog Institute to implement the LifeSpan model.⁴

New South Wales

Living Well: A Strategic Plan for Mental Health in NSW 2014 - 2024

- 1.10 The NSW Government's approach to suicide prevention for children and young people is guided by *Living Well: A Strategic Plan for Mental Health in NSW 2014-2024* (Living Well).⁵ Developed by the Mental Health Commission of New South Wales (NSW MHC), Living Well sets out a number of actions required for suicide prevention including the preparation of a NSW Suicide Prevention Implementation Plan.
- 1.11 Living Well emphasised that suicide prevention needs a systems approach.⁶ A systems approach requires the implementation of multiple evidence-based strategies simultaneously within a particular region.

LifeSpan – in New South Wales

- 1.12 As part of the actions recommended in Living Well, the NHMRC Centre for Research Excellence in Suicide Prevention (CRESP) and the Black Dog Institute were commissioned to develop a systems based framework for suicide prevention.⁷
- 1.13 The LifeSpan framework involves the implementation of nine evidence based strategies simultaneously within a local area. Under the framework each of the strategies are tailored to the local area and include:
 - improving emergency and follow-up care for suicidal crisis;

² National Mental Health Commission, [Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services](#), December 2014

³ National Mental Health Commission, [Contributing Lives, Thriving Communities – Review of Mental Health Programmes and Services](#), December 2014, Volume 1, p 112

⁴ The LifeSpan model is discussed further at paragraphs [1.12 – 1.16]

⁵ Submission 46, [NSW Government](#), p 3

⁶ Mental Health Commission of New South Wales, [Living Well: A Strategic Plan for Mental Health In NSW 2014 – 2024](#), October 2014, p 37

⁷ Submission 46, [NSW Government](#), p 8

- using evidence-based treatment for suicidality;
- equipping primary care to identify and support people in distress;
- improving the competency and confidence of frontline workers to deal with suicidal crisis;
- promoting help-seeking, mental health and resilience in schools;
- training the community to recognise and respond to suicidality;
- engaging the community and providing opportunities to be part of the change;
- encouraging safe and purposeful media reporting; and
- improving safety and reducing access to means of suicide.⁸

1.14 In New South Wales a research trial of LifeSpan is being undertaken in four areas with the lead agencies being a combination of PHNs and Local Health Districts (LHDs):⁹

Area	Lead agency	Date
Newcastle	Hunter New England LHD in partnership with Hunter New England Central Coast PHN, Hunter Primary Care, Calvary Ltd and Everymind	Commenced September 2017
Illawarra Shoalhaven	Coordinaire – the South East New South Wales PHN	Commenced September 2017
Central Coast	Central Coast LHD	Commenced August 2018
Murrumbidgee	Murrumbidgee PHN	Commenced August 2018

1.15 The above four trials are privately funded with the support of the NSW Government. The Black Dog Institute indicates that the LifeSpan model will be implemented using a staged roll out with each of the areas supported over a two and half year period.¹⁰

1.16 In addition to the above four trials, the LifeSpan team within the Black Dog Institute supports the NSPTs. Twelve sites across Australia have been selected to receive funding to participate in the NSPTs. The North Coast and Western New South Wales are the two areas selected in New South Wales.

⁸ Submission 41, [Black Dog Institute](#), pp 1-2

⁹ See LifeSpan sites at <https://www.blackdoginstitute.org.au/research/lifespanspan/lifespanspan-sites> accessed on 17 August 2018

¹⁰ See LifeSpan sites at <https://www.blackdoginstitute.org.au/research/lifespanspan/lifespanspan-sites> accessed on 6 August 2018

NSW Youth Health Framework 2017-2024

- 1.17 The NSW Youth Health Framework 2017 – 2024 is a policy aimed at supporting NSW Health to consider the health and wellbeing of young people aged 12 – 24 years when planning and delivering services. The goals of the framework include:
- that the health system responds to the health needs of young people, including targeted responses for vulnerable young people;
 - that health services are accessible and young people are engaged and respected; and
 - that young people are supported to optimise their health and wellbeing.¹¹

Mental Health Commission of New South Wales

- 1.18 The NSW MHC is an independent body established under the *Mental Health Commission Act 2012* with the purpose of monitoring, reviewing and improving the New South Wales mental health system.
- 1.19 The NSW MHC developed Living Well and currently monitors and reviews the progress of achieving the actions contained in Living Well.¹²
- 1.20 With the NSW Ministry of Health, the NSW MHC co-chairs the NSW Suicide Prevention Advisory Group (SPAG). SPAG meets twice a year and was established to 'ensure all organisations involved in suicide prevention in New South Wales could share knowledge about program performance, understand service gaps and avoid duplication.'¹³
- 1.21 The NSW MHC recently announced a whole-of-population, suicide prevention framework for New South Wales.¹⁴ Oversight of the framework rests with SPAG.¹⁵ In evidence before the Committee, Commissioner Catherine Lourey of the NSW MHC outlined the elements of the proposed suicide prevention framework:

They are enhancing coordination and integration; enhancing capacity to respond to suicide in local communities; inclusion of people's lived experience in those processes as better understanding of the contributors to suicide, which is essential in responding to it; building community resilience and wellbeing; supporting and promoting evidence-based practice; and supporting excellence in clinical services. The plan we have is in a cross-government committee, which is co-chaired by myself and the Director Mental Health in the New South Wales Ministry of Health, will have a comprehensive framework for all agencies to guide their work. Coordination is essential, and this is the first step in making sure that agencies understand their own

¹¹ NSW Health, [NSW Youth Health Framework 2017 – 2024](#), July 2017, p 3

¹² Submission 11, [Mental Health Commission of New South Wales](#), p 4

¹³ Submission 11, [Mental Health Commission of New South Wales](#), p 4

¹⁴ The Strategic Framework for Suicide Prevention in NSW 2018-2023 was released on 17 October 2018, shortly before the Committee published its report. The Framework was being prepared concurrently with the Committee's report, and at the time of writing was a proposed framework.

¹⁵ Submission 11, [Mental Health Commission of New South Wales](#), p 4

role and, where they are planning or responding to a community, there is an agreed approach and the evidence is there to bring to bear.¹⁶

NSW Child Death Review Team

- 1.22 The NSW Child Death Review Team (CDRT) reviews the deaths of all children aged from birth to 17 years.¹⁷ The NSW Ombudsman is the convenor of the CDRT, and the NSW Advocate for Children and Young People, the Community and Disability Services Commissioner, and a range of government representatives and independent experts are members.
- 1.23 Separately to the CDRT, the NSW Ombudsman is responsible for reviewing the deaths of children aged from birth to 17 years who die as a result of abuse or neglect, or in suspicious circumstances, and children who die in care or detention ('reviewable deaths').¹⁸
- 1.24 The purpose of the CDRT is to prevent and reduce child deaths. To fulfil their functions, the CDRT and the NSW Ombudsman maintain a register of child deaths in New South Wales which can be used to identify trends and patterns. They also undertake research and make recommendations to government and non-government agencies that aim to prevent or reduce the likelihood of child deaths.¹⁹

Non-government sector

- 1.25 As discussed above, there are a range of non-government agencies and community groups that play a role in youth suicide prevention and often have overlapping responsibilities with government or each other. Such organisations often receive funding from government.
- 1.26 Organisations and services can be online, via the telephone or face to face. They can include service providers, academics, researchers, workplaces, families, friends and individuals.

Improvements to current framework

Shared responsibilities and coordination

- 1.27 Many inquiry participants acknowledged that suicide prevention is a joint responsibility shared between all levels of government.²⁰ The NSW MHC submitted:

¹⁶ Commissioner Lourey, Commissioner, Mental Health Commission of New South Wales, [Transcript of evidence](#), 12 February 2018, p 32

¹⁷ *Community Services (Complaints, Reviews and Monitoring) Act 1993*, Part 5A

¹⁸ *Community Services (Complaints, Reviews and monitoring) Act 1993*, Part 6; Submission 45, [NSW Child Death Review Team](#), p 2

¹⁹ Submission 45, [NSW Child Death Review Team](#), p 2

²⁰ For example see: Submission 11, [Mental Health Commission of New South Wales](#), p 3; Submission 41, [Black Dog Institute](#), p 3; Submission 12, [National Mental Health Commission](#), p 4; Submission 19, [Orygen](#), p 3

Suicide prevention is a shared Commonwealth and state responsibility. A large number of community-managed organisations also undertake suicide prevention activities at national, state, regional and local community levels.²¹

1.28 With shared responsibilities comes the need to ensure there is effective coordination and governance. The NSW MHC further submitted that the Fifth Plan provides an opportunity to establish formal governance mechanisms between the states, territories and the Commonwealth.²²

1.29 The NSW MHC also highlighted that the profile of suicidality and available services varies between regions. As such, assessments of what services are required should occur at a local level. The NSW MHC submitted that PHNs are well-placed to create regional plans and provide a coordinating role with local councils and LHDs. In its view, the Our Healthy Clarence plan is a model of this working well.²³

CASE STUDY: OUR HEALTHY CLARENCE

In response to the increased number of youth suicides over recent years, Clarence Valley Council worked with the community, government departments and local organisations on two initiatives to address concerns.

- 1) The Our Healthy Clarence Plan is an overall mental health and wellbeing plan with strategies that specifically address suicide prevention and postvention. The plan is well developed with 18 organisations, youth and community representatives working together to achieve the plan.
- 2) The Clarence Youth Action group developed in May 2016 is a platform for young people to participate in community development. The group has evolved to have its own logo, terms of reference, strategic plan, executive structure and communications strategy. The group plays a strong role in helping to decide funding priorities for youth facilities and services and in encouraging greater participation by young people in a range of community initiatives.

Source: Submission 11, [Mental Health Commission of New South Wales](#), p 3

1.30 In their joint submission, Lifeline, batyr and Orygen recognised the work of suicide prevention networks (SPNs) operating across New South Wales and recommended the NSW Government continue to support and build upon those already in operation:

The development of regional SPNs recognises the need for community mapping and needs analysis to; explore how these can become better coordinated or streamlined; uncover service gaps; promote collaboration; estimate costs and plan next steps.

²¹ Submission 11, [Mental Health Commission of New South Wales](#), p 3

²² Submission 11, [Mental Health Commission of New South Wales](#), p 3

²³ Submission 11, [Mental Health Commission of New South Wales](#), pp 3 - 4

...

This approach acknowledges the need to build relationships and take a community-led focus to suicide prevention, where professional services and community action work together.²⁴

- 1.31 The NMHC also acknowledged that governance and accountabilities for suicide prevention exist at the national, state and regional level. The NMHC indicated that under the Fifth Plan, a new Suicide Prevention Subcommittee of the Mental Health, Drug and Alcohol Principal Committee will be established. This group will set future directions for planning and investment and develop a National Suicide Prevention Implementation Plan.²⁵
- 1.32 The NMHC echoed the views of the NSW MHC in that suicide prevention services need to be suitable and effective at a local level. The NMHC submitted that the new role of the PHNs, particularly through the 12 NSPTs, provides an opportunity to introduce regionally appropriate suicide prevention models in a coordinated way.²⁶
- 1.33 The NMHC will be required to report annually to Health Ministers on the implementation progress of the Fifth Plan.²⁷
- 1.34 In its submission Orygen pointed to criticisms of suicide prevention activities in the past as being 'fragmented, piecemeal and uncoordinated' in their approach to suicide prevention.²⁸ Orygen referred to the number of regionally led suicide prevention trials either commenced or foreshadowed in New South Wales and submitted that the NSW Government is 'well positioned to ensure these large-scale government efforts are coordinated.'²⁹
- 1.35 The Black Dog Institute also recognised that there are a range of suicide prevention activities at 'individual, local, organisational (work, school), council, health district, primary health care, State and Federal levels.'³⁰ In referring to the Commonwealth's use of the PHNs to coordinate suicide prevention activities, the Black Dog Institute stressed the importance of not duplicating existing efforts:

... the implementation of an integrated plan must involve a regional response in order to align organisations to a framework that is effective and efficient. In the UK, this has been the Trusts, in Australia the approach taken by the Commonwealth is through the PHNs. It is important that whatever coordinating mechanism is used, it builds on rather than duplicates efforts already underway, e.g. through the 12 Commonwealth suicide prevention trials.³¹

²⁴ Submission 34, [Batyr, Lifeline and Orygen](#), p 8

²⁵ Submission 12, [National Mental Health Commission](#), p 4

²⁶ Submission 12, [National Mental Health Commission](#), p 4

²⁷ Submission 12, [National Mental Health Commission](#), p 4

²⁸ Submission 19, [Orygen](#), p 3

²⁹ Submission 19, [Orygen](#), p 4

³⁰ Submission 41, [The Black Dog Institute](#), p 3

³¹ Submission 41, [The Black Dog Institute](#), p 3

- 1.36 Beyond Blue highlighted the importance of collaboration between levels of government and the sharing of knowledge. Beyond Blue submitted:

The most successful model will combine a mix of national and jurisdiction-specific approaches, integrating evidence-based interventions managed locally, combined with selective initiatives supported at a national level (e.g. helplines, resource development, campaigns).³²

- 1.37 In evidence before the Committee, Dr Nigel Lyons, Deputy Secretary, Strategy and Resources, Ministry of Health commented on the role NSW Health has in implementing the Fifth Plan:

The phase we are now moving into is to ensure that there is alignment with the work we are doing in a range of different areas that complements and supports the implementation of the fifth national mental health plan. ... In particular, we are keen to ensure that there is alignment with our Living Well strategy, which is a 10-year strategy in New South Wales, and that where there is no complete alignment we adjust our approach to ensure we are achieving the outcomes in the fifth national mental health plan.³³

Committee Comment

- 1.38 The Committee acknowledges that governance of suicide prevention activities is complex due to the interconnected responsibilities of all levels of government, departments and agencies within governments, non-government agencies and community organisations
- 1.39 The Committee is encouraged by the announcement of the Fifth Plan, which occurred during the course of the inquiry. In particular, the Committee notes the focus on suicide prevention as a priority area. The Committee agrees with the NSW MHC in that the Fifth Plan provides an opportunity to establish formal governance mechanisms between the states, territories and the Commonwealth.
- 1.40 As the Fifth Plan has only been in operation for a year, the Committee does not consider it can comment on the effectiveness of the plan or its governance arrangements. However, the Committee's preliminary view is one of support for the involvement of the PHNs and LHDs in developing whole of community approaches to suicide prevention. The Committee will be interested in the first report on the implementation progress of the Fifth Plan by the NMHC in October 2018.
- 1.41 Despite the announcement of the Fifth Plan, the Committee considers that the recently announced Strategic Framework for Suicide Prevention in NSW 2018-2023 is still an important strategy for New South Wales. A state-based suicide prevention strategy can respond to issues unique to New South Wales and provide a governance structure for New South Wales agencies. However, the Committee notes that the strategy developed by the NSW MHC should align with the Fifth Plan.

³² Submission 51, [Beyond Blue](#), p 18

³³ Dr Nigel Lyons, Deputy Secretary, Strategy and Resources, Ministry of Health, [Transcript of evidence](#), 5 March 2018, p 54

- 1.42 The Committee also considers that Strategic Framework for Suicide Prevention in NSW 2018-2023 would benefit from supporting and incorporating community led activities similar to the Our Healthy Clarence plan.

Recommendation 1

The Committee recommends that the Mental Health Commission of New South Wales ensures that the Strategic Framework for Suicide Prevention in NSW 2018-2023 aligns with the Fifth National Mental Health and Suicide Prevention Plan.

Recommendation 2

The Committee recommends that the Mental Health Commission of New South Wales ensures that the Strategic Framework for Suicide Prevention in NSW 2018-2023 supports and incorporates community led suicide prevention activities.

Youth specific suicide prevention plan

- 1.43 The Committee received evidence on the benefits of a youth specific suicide prevention plan. Orygen submitted that from their research, stakeholders and young people consider that suicide prevention looks different for young people and that existing plans do not respond to the unique needs of children and young people.³⁴ Orygen suggested a separate youth suicide prevention plan be considered with the following elements:

- developed in partnership with young people;
- reflect evidence-based practice shown to be effective for this age group; and
- provide a targeted suite of actions and program delivery that is accessible and acceptable to young people.³⁵

- 1.44 Orygen highlighted that Tasmania is the only state that has a youth specific suicide prevention plan:

Probably the only State in the country that has a separate youth plan is Tasmania. We were involved in helping them develop that. There they were very keen, they recognised that youth suicide looks a bit different and youth suicide prevention needs to look a bit different than suicide prevention across the adult age range. They developed a State-based suicide prevention strategy with a youth implementation plan that sat alongside it or underneath it that really spoke to the needs of young people and talked about some of those areas or opportunities for youth suicide prevention that sometimes we miss when we look at it across the age range.³⁶

- 1.45 In their submission, Orygen referred to their 2016 report, *Raising the bar for youth suicide prevention*. In that report Orygen provided a number of reasons as to why a youth specific response to suicide prevention is required:

³⁴ Submission 19, [Orygen](#), pp 4 - 5

³⁵ Submission 19, [Orygen](#), p 5

³⁶ Dr Jo Robinson, Senior Research Fellow, Orygen, [Transcript of evidence](#), 12 February 2018, p 46

- there is increased susceptibility to the onset of mental ill-health during this period of life;
- the rates of self-harm are unacceptably high; and
- an analysis of suicide cluster data shows that youth suicide is more likely to be part of a cluster than an adult suicide.³⁷

1.46 Mental Health Carers NSW similarly argued that there should be a separate plan that specifically focuses on youth suicide prevention because the mental health needs of young people are complex and influenced by many different factors.³⁸

1.47 The joint submission from Lifeline, batyr and Orygen acknowledged the proposed suicide prevention strategy for New South Wales and recommended that ‘an explicit segment on youth suicide prevention in this plan should promote the coordination of activities, programs and responsibilities across the State.’³⁹

1.48 The CDRT submitted a similar view arguing that it is imperative that any suicide prevention plan has a clear focus on children and young people:

We also consider it imperative that any such strategy has a clear focus on children and young people and includes specific measures that go across the spectrum of need: from universal strategies that promote wellbeing in children and young people to early intervention designed to arrest emerging problems and difficulties to the provision of targeted, sustained and intensive therapeutic support to young people at high risk (including strategies for reaching those who are hard to engage).⁴⁰

1.49 In any development of youth specific suicide prevention policies or strategies, Youth Action stressed that it is critical for young people to be consulted and involved:

Young people are experts in their own experience and provide invaluable insight into the programs, barriers and supports they face to their mental health and wellbeing.⁴¹

1.50 The Committee will further discuss the importance of co-design in Chapter Three.

Committee comment

1.51 Our children and young people have specific needs and as highlighted by inquiry participants, there are valid reasons as to why youth specific responses are appropriate. The Committee considers that developing a youth specific suicide prevention plan will assist in focusing attention on children and young people and guide decision making.

1.52 Ideally, the Committee considers a standalone youth suicide prevention plan is warranted, similar to the plan introduced in Tasmania in 2016. If a standalone plan is not adopted, then a specific section on children and young people should be

³⁷ Orygen, [Raising the bar for youth suicide prevention](#), November 2016, p 7

³⁸ Submission 49, [Mental Health Carers NSW](#), p 2

³⁹ Submission 34, [Lifeline, batyr, Orygen](#), p 2

⁴⁰ Submission 45, [NSW Child Death Review Team](#), p 15

⁴¹ Submission 52, [Youth Action](#), p 10

incorporated into the Strategic Framework for Suicide Prevention in NSW 2018-2023 prepared by the NSW MHC.

- 1.53 The Committee also recommends that any proposed plan should be co-designed by children and young people.

Recommendation 3

The Committee recommends that the NSW Government develop a youth specific suicide prevention plan developed in consultation with children and young people.

Whole of NSW Government approach

- 1.54 Similar to suicide prevention being a joint responsibility across all levels of government, many inquiry participants recognised that suicide prevention involves a number of portfolios within government.

- 1.55 In their submission, the NSW Government commented:

The NSW Government takes a Whole of Government, system wide approach to suicide prevention, recognising that suicide is a complex problem, and that only by addressing whole of health and community interactions, can suicide rates be reduced.⁴²

- 1.56 The CDRT similarly submitted that given there are a number of government and non-government agencies with roles and responsibilities relating to youth suicide, a whole of government response is required:

In relation to youth suicide, we note that there are a broad range of government and non-government agencies in New South Wales with roles and responsibilities relating to the support of children and young people at risk, including in relation to the provision of:

- NSW Health services, including acute, community based, and specialist adolescent mental health programs and services e.g. CAMHS.
- Commonwealth services, including those targeted to youth mental health e.g. Headspace.
- Education services, including school counsellors, welfare programs and postvention supports in schools.
- Child protection services, including responsibility for responding to risk of significant harm, reports about self-harm and suicidal behaviours, and for the health and wellbeing of young people in the care of the Minister.

In this context, we consider that a focused whole-of-government approach to suicide prevention is warranted.⁴³

- 1.57 Orygen submitted that historically the responsibility for suicide prevention has been positioned within health and mental health portfolios due to the correlation

⁴² Submission 46, [NSW Government](#), p 3

⁴³ Submission 45, [NSW Child Death Review Team](#), pp 14 - 15

between poor mental health and suicide risk amongst young people. However, in its view there are a range of other factors that can impact suicidality and there is a case for including these in any suicide prevention response:

... suicide and suicide risk are also impacted by a range of social and economic determinants, including loss of industry, housing affordability, family breakdown and high costs of education and training. As such, there is a strong case for governance to include the breadth of portfolios and departments accountable for these areas.⁴⁴

- 1.58 Orygen further submitted that one approach to support a whole of government response is to position the overall governance of suicide prevention within the Department of Premier and Cabinet. Orygen contended that it could then be articulated as one of the ‘Premier’s Priorities’ with accountabilities spread across public entities, departments and portfolios.⁴⁵ In evidence before the Committee, Dr Jo Robinson, Orygen expanded on this:

... positioning it potentially as a Premier’s Priority so that the mandate is there to bring together all the different departments and portfolios so that they are able to articulate what role and responsibility they can play and then also be measured on that and have targets and accountabilities so that everyone is working together.⁴⁶

- 1.59 The joint submission from Lifeline, batyr and Orygen made similar comments to that of Orygen. They advocated for a central agency to have responsibility as they have experienced being ‘bounced’ between portfolios and have seen an unwillingness of departments to ‘own’ issues or solutions:

While mental health and suicide prevention currently falls under the health portfolio, our organisations believe a whole-of-government response – incorporating education, employment, health, social services, housing and justice is also necessary. For instance, if NSW Premier and Cabinet was the central agency for suicide prevention, responsible for driving cross-portfolio collaboration and interdepartmental actions, there would be better outcomes for the state’s young people.⁴⁷

- 1.60 Similarly, the Black Dog Institute submitted that that there are no clear governance arrangements across the many regional, State or Commonwealth activities and contend that they require oversight by one agency with influence across sectors. The Black Dog Institute commented:

This oversight and coordination role would need to monitor, evaluate and assess the activities supported by State and Commonwealth governments, plus those undertaken by regional organisations, such as PHNs. Input would be required from education departments, peak organisations, and not for profit and community organisations.⁴⁸

- 1.61 When questioned on the issue of suicide prevention governance being better placed within the Department of Premier and Cabinet, the Deputy Secretary of

⁴⁴ Submission 19, [Orygen](#), p 4

⁴⁵ Submission 19, [Orygen](#), p 4

⁴⁶ Dr Robinson, [Transcript of evidence](#), 12 February 2018, p 46

⁴⁷ Submission 34, [Lifeline, batyr and Orygen](#), p 3

⁴⁸ Submission 41, [The Black Dog Institute](#), p 3

Health commented that NSW Health regards its role in suicide prevention as important and is very keen to continue to take a leadership role:

Within Health we have certainly demonstrated that we believe it is an important role that we play. Increasingly, we are thinking not just about the response to people who need care in acute settings; it is about what we do outside of acute care. Increasingly, health promotion, disease prevention and illness prevention strategies are important from our perspective because it will prevent the need for care ultimately and provide a better life and greater wellbeing for individuals and communities.

We are very keen to take a lead in that regard. If I give you the example of Living Well, which is our current strategy for reforming mental health care in New South Wales, Health is leading that approach. We are taking a leadership responsibility with the other government departments actively involved – Education, FACS, Justice, Treasury and DPC all attend those meetings and are very active contributors to the strategies that are in Living Well.⁴⁹

Committee comment

- 1.62 The Committee agrees with inquiry participants that youth suicide prevention requires a whole of government response. The causes of suicide are complex and involve varied social and economic factors. Approaches that include multiple departments and agencies will provide better outcomes for children and young people.
- 1.63 The Committee acknowledges the evidence advocating for a central agency to have responsibility for the development and oversight of suicide prevention activities. The Committee considers that NSW Health has the experience to continue in this capacity. The Committee also considers that given the current suicide prevention trials underway in New South Wales, which are headed up by a combination of PHNs and LHDs, NSW Health is well positioned to monitor and evaluate the trials and share this knowledge with other departments and stakeholders.

Evaluation and sharing of outcomes

- 1.64 During the inquiry, the Committee heard about the importance of implementing evidence-based programs and services. Many inquiry participants indicated that suicide prevention programs and activities need to be supported by proper evaluation and all results ideally shared with other governments and non-government agencies.
- 1.65 In their submission, Orygen commented that a criticism of suicide prevention efforts over the past decade has been the ‘paucity of quality evaluations.’⁵⁰ This has led to gaps in what works and what does not. Orygen commented:

... it is important that future NSW government suicide prevention activities are supported by an evaluation framework, one which can be applied consistently across funded programs. It is also important that program budgets incorporate evaluation

⁴⁹ Dr Lyons, [Transcript of evidence](#), 5 March 2018, p 53

⁵⁰ Submission 19, [Orygen](#), p 3

costs and that the framework is developed to be appropriate for young people and utilises modalities and methodologies that they find accessible.

1.66 Orygen submitted that efforts to coordinate and integrate evidence-based programs and services across New South Wales could be improved by:

- A national 'better practice register' of suicide prevention programs and interventions, for which Suicide Prevention Australia has recently received Australian Government funding to deliver.
- All governments agreeing on and adopting mechanisms through which information on suicide prevention activities, funding and evaluations can be shared and updated.⁵¹

1.67 As mentioned above, Orygen suggested that given the number of suicide prevention trials being conducted in New South Wales, the NSW Government is uniquely placed to monitor the outcomes of these trials and share those results:

It is important that the progress and outcomes emerging from these sites are monitored and shared, particularly regarding their efficacy and appropriateness across a range of population groups (including young people) and locations (rural compared to metro).⁵²

1.68 Similarly, the CDRT highlighted the importance of evaluating suicide prevention strategies:

The complexity and causative or contributory factors in youth suicide presents challenges in identifying interventions that are most effective in preventing suicide. In this context, evaluation of suicide prevention strategies is critical to inform best practice and identification of effective strategies to guide future efforts

1.69 Ms Jaelea Skehan, Director, Everymind, also commented on the current need for investment in quality evaluation research in order to make best use of investments in programs:

We could really do with some further investment in good-quality evaluation research to understand that we are applying the best available evidence and also to establish what is working and why. I go to the international congresses dealing with suicide prevention and we are a member of the International Association for Suicide Prevention. We have had government investment in suicide prevention at all levels in Australia that many countries have not had. We are lucky in that regard. However, making the best use of that investment is also vitally important.⁵³

1.70 In evidence before the Committee, the Deputy Secretary of Health outlined the approach NSW Health undertakes when evaluating programs and services:

For each program—and this is one of the things we do for any newly trialled or tested approach—is to be very clear about what we are intending to achieve from that program, that project, and having that clarity at the start is really important. Secondly, we should agree on the sorts of things we can measure. They may be shorter term

⁵¹ Submission 19, [Orygen](#), p 3

⁵² Submission 19, [Orygen](#), p 4

⁵³ Ms Jaelea Skehan, Director, Everymind, [Transcript of evidence](#), 27 November 2017, p 9

process measures, clinical outcomes or clinical care activities that will give us a sense that ultimately they will achieve the outcome. Sometimes the outcomes are longer term; they may be years down the track. What should we start to collect now that will give us a sense of whether or not this program will be effective? That is the quantitative side of things. There is usually also a qualitative side. That would involve some assessment of the individuals who have been through the program or project and asking about their experience or how they found it. In addition, we usually work with the health providers to ensure that what they are involved in is effective from their perspective. It involves the experience of the patient, the carer and the family, and also the experience of the providers. What is their experience of the project? Is it working?⁵⁴

Committee comment

- 1.71 The Committee recognises the importance of conducting proper evaluations of programs and services. Particularly given the complexities surrounding the causal factors of youth suicide, understanding what works and what does not is important.
- 1.72 Similar to the introduction of the Fifth Plan, the Committee is encouraged by the number of LifeSpan trial sites in New South Wales. The LifeSpan model has been supported by numerous stakeholders and presents an opportunity for New South Wales to monitor the trials and evaluate what works and what does not.
- 1.73 The Committee considers that the evaluation should include an assessment of the effectiveness of LifeSpan programs for children and young people in both regional, rural and remote areas and metropolitan areas.
- 1.74 The trial sites also provide an opportunity for the NSW MHC to incorporate any learnings and positive outcomes into the Strategic Framework for Suicide Prevention in NSW 2018-2023.

Recommendation 4

The Committee recommends that the NSW Government monitor and evaluate the progress of the LifeSpan trial sites in New South Wales and share outcomes with other governments in relation to the model's effectiveness and appropriateness for children and young people in regional, rural and remote areas and metropolitan areas.

Navigating the programs and services available

- 1.75 A topic that arose during the inquiry was the amount of programs and services available and the difficulties associated with navigating the system. The Director, Everymind, commented:

The suicide prevention sector is evolving and changing at the community level all the time. There will always be other smaller community responses to a particular issue, driven through local leads and others.... We will be tasked with developing a new suicide prevention portal, which is funded nationally, to try and capture some of that

⁵⁴ Dr Lyons, [Transcript of evidence](#), 5 March 2018, p 51

in a meaningful way, which will be up and running as a minimum viable product by the end of the year and enhanced over the next two years.⁵⁵

- 1.76 Mr Jonathan Nicholas, Chief Executive Officer, ReachOut, commented on the challenges of knowing what services are available in a particular area that a young person can be referred to and indicated mapping of services at a LHD level would be beneficial:

How can we most efficiently and effectively move those young people on to further services? That is really about better integrating the digital world with the offline world, so that a young person in a rural area we can geolocate using mobile data so that it only pops up with services if you live in Griffith. But we actually need the mapping of those services at a local health district [LHD] level so that we know where that young person can go.⁵⁶

- 1.77 The Committee notes the work of Suicide Prevention Australia and its partners in the launch of the Suicide Prevention Hub in May 2018. The Hub is an online resource aimed at supporting communities to find evidence based suicide prevention programs and services. All programs and services that will be listed on the Suicide Prevention Hub will have been independently assessed by expert reviewers.⁵⁷

Committee comment

- 1.78 The Committee was made aware of the many organisations providing a number of suicide prevention programs and services to children and young people. Such programs and services range from universal activities targeting the whole population to youth specific and acute care activities. The Committee notes that inquiry participants agreed that any programs and services used should be evidence-based.
- 1.79 Navigating through the amount of programs and services available can be challenging for both children and their parents, especially when a child or young person may be experiencing distress.
- 1.80 The Committee acknowledges the recently announced Suicide Prevention Hub, an online resource that will assist communities to find suicide prevention programs and services that have been evaluated. However, the Committee considers this online directory may be more tailored to adults and health professionals as opposed to children and young people. As such, the Committee considers there is merit in developing an online directory specifically targeted for children and young people to access. The directory should be co-designed by children and young people and map programs available by geolocation and local health district.

⁵⁵ Ms Skehan, [Transcript of evidence](#), 27 November 2018, p 17

⁵⁶ Mr Jonathan Nicholas, Chief Executive Officer, ReachOut, [Transcript of evidence](#), 12 February 2018, p 52

⁵⁷ See: The Suicide Prevention Hub, Media release, 1 May 2018 accessed at <http://suicidepreventionhub.org.au/news/media-release-australia-first-suicide-prevention-hub-now-inviting-submissions> on 20 August 2018

Recommendation 5

The Committee recommends that the NSW Government develop an online directory of programs and services specifically targeted for children and young people to access. The directory should be co-designed by children and young people, and map programs available by geolocation and local health district.

Chapter Two – Vulnerable and at-risk children and young people

- 2.1 This Chapter focuses on groups of children and young people at greater risk of suicide. Unfortunately children and young people at a higher risk of suicide include those who:
- a) have a child protection history;⁵⁸
 - b) are Aboriginal and Torres Strait Islander;⁵⁹
 - c) are male;⁶⁰
 - d) live in rural, regional and remote areas;⁶¹
 - e) are LGBTI.⁶²
- 2.2 Other groups of children and young people at particular risk include those children and young people in the juvenile justice system,⁶³ or who have an eating disorder (especially anorexia nervosa),⁶⁴ personality disorders⁶⁵ or anxiety,⁶⁶ and those who are homeless.⁶⁷

Children and young people with a child protection history

- 2.3 Of all the vulnerable and disadvantaged groups, children under 18 with a child protection history appear to be at highest risk. A 10-year review commissioned by the CDRT found that, while there was a significant decline in suicide mortality rates among children generally, there was no change in the rate of children with a child protection history.⁶⁸ Also troubling is that the number of children who died by

⁵⁸ Submission 45, [NSW Child Death Review Team](#), p 5

⁵⁹ Submission 45, [NSW Child Death Review Team](#), p 5

⁶⁰ Submission 45, [NSW Child Death Review Team](#), p 5, although, the rate of suicide for females under 18 has increased in recent years; Ms Douglas, National Manager, headspace Schools Support, [Transcript of evidence](#), 5 March 2018, p 26

⁶¹ Submission 45, [NSW Child Death Review Team](#), p 5

⁶² Submission 29, [ACON](#), p 4

⁶³ Submission 47, [Advocate for Children and Young People](#), p 3

⁶⁴ Submission 42, [Australian College of Mental Health Nurses](#), p 10

⁶⁵ Submission 19, [Orygen](#), p 2; see also Submission 28, [University of Wollongong: School of Psychology](#), pp 7 – 8

⁶⁶ Submission 24, [Macquarie University: Centre for Emotional Health](#), p 2

⁶⁷ Submission 47, [Advocate for Children and Young People](#), p 6; see also Submission 48, [Mission Australia](#), p 6

⁶⁸ Submission 45, [NSW Child Death Review Team](#), p 6, citing NSW Child Death Review Team (2014), [Causes of death of children with a child protection history 2002-2011](#), report by the Australian Institute of Health and Welfare. In the report, 'child protection history' is defined as:

- For 2002-2009 inclusive: children, siblings of children, who were the subject of a report of risk of harm to the (then) Department of Community Services within three years prior to their death.
- For 2010-2011 inclusive: children, or siblings of children, who were the subject of a report of risk of harm/significant harm to Community Services within three years prior to their death, and/or children, or

suicide who were known to the Department of Family and Community Services (FACS) has also recently increased from 7% (5) of all children who died and were known to FACS in 2013 to 12% (11) in 2016.⁶⁹

Children and young people in out-of-home care

2.4 The CDRT submitted that their reviews have consistently identified young people in out-of-home care as particularly vulnerable. In the CDRT's *2017 Report of Reviewable Deaths in 2014 and 2015*, the CDRT included a focused review of 15 young people (aged 13-17 years) who were in out-of-home care and died by suicide or in a risk-taking context between 2004 and 2015. The CDRT identified that nine of the 15 young people died by suicide and all had high and complex support needs, with involvement by multiple agencies to address escalating and significant risks.⁷⁰ For these young people, the CDRT identified:

...problems and challenges in relation to establishing and sustaining the engagement of young people in therapeutic support services, effectively coordinating support across services and practitioners, and managing the risks/meeting the intensive ongoing support needs of these young people.⁷¹

2.5 Some observations that the CDRT made included that:

- more than half of young people repeatedly declined assistance or only engaged with services sporadically;
- almost all the young people were the subject of multiple reports to FACS, with these reports either screened out for not meeting the threshold for statutory intervention or the response had a narrow focus; and
- interagency communication and coordination was less than optimal.⁷²

2.6 To address these concerns the CDRT recommended that FACS provide details of current or proposed strategies with particular regard to:

- responses to risk of significant harm reports, particularly those that raise concerns about self-harm and risk-taking behaviours (including suicide attempts or threats of suicide, and substance abuse)
- identification of, and response to, escalating self-harm/risk-taking behaviours, and
- lack of placement stability and homelessness.⁷³

2.7 In answers to questions on notice, the CDRT indicated that FACS accepted all the recommendations in full and is working on addressing the concerns. FACS

siblings of children, who were the subject of a report of risk of harm to a Child Wellbeing Unit within three years prior to their death.

⁶⁹ Department of Family and Community Services, [Child Deaths Annual Report 2016](#), p 17

⁷⁰ Submission 45, [NSW Child Death Review Team](#), pp 5 - 6

⁷¹ Submission 45, [NSW Child Death Review Team](#), p 12

⁷² Submission 45, [NSW Child Death Review Team](#), p 13

⁷³ NSW Child Death Review Team, [Answers to questions taken on notice](#), 26 February 2018, p 2

indicated that they are working on a number of strategies including measures within the Their Futures Matters reforms such as a Trauma Treatment Service for children in out-of-home care.⁷⁴

- 2.8 The CDRT indicated that full details about the progress made by FACS will be reported in the next biennial report of the CDRT in early 2019.⁷⁵

Committee comment

- 2.9 The Committee is concerned by the unacceptably high rate of children and young people with a child protection history dying by suicide. With particular reference to children in out-of-home care, the Committee accepts that a process is underway whereby FACS is addressing the issues raised by the CDRT.
- 2.10 However, to the extent that the issues concern the coordination and communication between government agencies, the Committee considers that the NSW Government, as a whole, should do more to respond to this issue as an immediate concern.

Recommendation 6

The Committee recommends that the NSW Government develop, implement and monitor strategies around interagency co-ordination and communication to reduce the high rate of children and young people with a child protection history dying by suicide.

Aboriginal and Torres Strait Islander status

- 2.11 Aboriginal and Torres Strait Islander children and young people are another group who are particularly at risk. However, the Committee notes that it received evidence that for those with a child protection history, after controlling for other variables such as age, gender, and remoteness, being Aboriginal or Torres Strait Islander did not of itself increase the risk of a child under 18 dying by suicide.⁷⁶
- 2.12 In their submission the CDRT stated that 'while Aboriginal and Torres Strait Islander children and young people comprise less than five per cent of all children in New South Wales, they accounted for 10 per cent of all suicide deaths of children and young people over 15 years from 2002.'⁷⁷
- 2.13 Professor Philip Hazell, a member of the CDRT, stated in evidence that it is the exposure to multiple risks which places Aboriginal children at a high risk of suicide:

⁷⁴ NSW Child Death Review Team, [Answers to questions taken on notice](#), 26 February 2018, p 2

⁷⁵ NSW Child Death Review Team, [Answers to questions taken on notice](#), 26 February 2018, p 2

⁷⁶ Mr Barnes, NSW Ombudsman and Convenor, NSW Child Death Review Team, [Transcript of evidence](#), 12 February 2018, p 17

⁷⁷ Submission 45, [NSW Child Death Review Team](#), p 5

Aboriginal children manifest with the highest level of multiple risks. It is multiple risks to health, mental health, education and their capacity to live with their families. That places them at a high risk of a number of serious outcomes including suicide.⁷⁸

- 2.14 Professor Hazell further stated that the data concerning Aboriginal children and young people is consistent and the poor health outcomes for Aboriginal communities have been known for a long time. The challenge is to stay focused on this important issue:

The second point I want to amplify relates to the two vulnerable and overlapping groups who appear in the CDRT data; that is, children with a child protection history, particularly those who have been in out-of-home care, and Aboriginal and Torres Strait Islanders. These data stand out like a beacon compared with the rest of the data. I make the point that this is old news. We have been aware of the fact that these groups of young people are at risk of a range of poor health outcomes. The challenge, or the problem, for us is that other issues sometimes grab people's attention through promotion by lobby groups or the media, but they are not the main game or the most important issues facing our community.⁷⁹

- 2.15 Professor Pat Dudgeon, School of Indigenous Studies, University of Western Australia, echoed this point by commenting:

The factors that contribute to high Aboriginal and Torres Strait Islander suicide rates are very complex but interrelated and these can include the cumulative impacts of ongoing exposure to socio-economic disadvantage and multiple psychological stresses, and grief from the premature death of families, community members and friends, including suicide.

...

For a lot of families there is violence, interpersonal conflict, trans-generational trauma, grief, loss associated with the impact of dislocation and the forced removal of children, and mistreatment. For a lot of Aboriginal Australians there is still pervasive racism and discrimination at individual, institutional and system levels.⁸⁰

- 2.16 With regard to what are appropriate suicide prevention activities for Aboriginal children and young people, the Aboriginal Child, Family and Community Care State Secretariat (AbSec) emphasised that any program should be community owned:

... effective suicide prevention strategies for Aboriginal people, including Aboriginal youth, should be community owned and embedded, empowering Aboriginal communities to develop their own tailored responses through a cultural framework and involving community Elders.⁸¹

⁷⁸ Professor Philip Hazell, Independent member, NSW Child Death Review Team, [Transcript of evidence](#), 12 February 2018, p 20

⁷⁹ Professor Hazell, [Transcript of evidence](#), 12 February 2018, pp 17 - 18

⁸⁰ Professor Pat Dudgeon, School of Indigenous Studies, University of Western Australia, [Transcript of evidence](#), 30 April 2018, p 2

⁸¹ Submission 8, [Aboriginal Child, Family and Community Care State Secretariat](#), p 2

- 2.17 Similarly, the Advocate for Children and Young People commented that Aboriginal owned and controlled services are the preferred way children and young people wish to receive services:

Like everything we need to have more resources in the area of Aboriginal owned and controlled organisations, and I think part of the cultural change is understanding that Aboriginal owned and controlled organisations are not only most likely to provide the best outcomes but that the clients—Aboriginal children and young people—are saying that that is their preferred way to receive services.⁸²

- 2.18 Providing support for Aboriginal families and communities to help children and young people was also considered to be important to preventing suicide in this group. In evidence before the committee, Mr Charlie Faulkner, Chairperson, Awabakal Medical Service, reflected on two cases involving Aboriginal young boys where the outcome for one young boy was tragically different to the other. Mr Faulkner commented on what he considered the differences in care were for the two boys:

EXPERIENCES OF ABORIGINAL YOUNG PEOPLE

A young 17-year-old boy who was homeless, struggling to make connection with family, been removed, in the system, and unfortunately he took an overdose. We were seeing him weekly but because of our capacity weekly was not enough for this young boy and an institute was not where he wanted to go because he had been in and out of that. He certainly was not going to go to a hospital setting. The thing I think we did wrong was unfortunately not having enough support around him, providing a home or somewhere for him to be safe, accommodation, money, job opportunities, schooling opportunities: they are few things I think we did wrong.

On the other scale I have another young boy who has gone through the system into hospital settings, who started as a 14-year-old boy. He was in the system until he was 16. In the hospital setting from 14 to 16, for two years. In and out of the Nexus unit. He had family support. We were seeing him weekly with family support. Schooling was an issue but we worked another system out for that: we had a tutoring role supporter for him, part-time schooling at the hospital as well as at home. We had a dad and lots of aunties and uncles around. We supported that group to support that young person.

Source: Mr Faulkner, [Transcript of evidence](#), 27 November 2017, pp 5 - 6

- 2.19 Responding to what services would be most effective for Aboriginal children and young people, Professor Dudgeon commented:

As with any mental health issue, we need a stepped-care approach. I have found that communities like to deliver universal programs that bring people back to country and strengthen their culture and identity. We certainly need those programs. However,

⁸² Mr Andrew Johnson, NSW Advocate for Children and Young People, [Transcript of evidence](#), 12 February 2018, p 40

we also need immediate programs so that when children are in distress we can get a psychiatrist or psychological service immediately. There will be different needs for different issues.⁸³

2.20 The Committee notes the work of the Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project (ATSISPEP) which produced its final report in 2016, *Solutions that Work: what the evidence and our people tell us*.⁸⁴ From the research of the ATSISPEP project, programs that show results for the prevention of suicide for Indigenous young people are those that:

- invest in locally based upstream approaches that promote young people's connectedness, sense of belonging, stability, hope and control over their life and future;
- are activity based and foster connection to cultural practices and identity;
- support young people to have a vision for their future;
- have a focus on recovery and healing from stress and trauma;
- utilise digital technology;
- are peer led and utilise the role of youth workers and others in less formal relationships with young people;
- enhance communication between family members and within communities;
- are both clinical and culturally based and provided 24 hours a day.⁸⁵

2.21 The NSW Government submitted that they are committed to 'closing the gap in health outcome disparity between Aboriginal and non-Aboriginal people and ensuring the unique needs of particular communities and populations are met.'⁸⁶

2.22 In its submission, the NSW Government detailed a number of programs and efforts NSW Health is engaged in to support the needs of Aboriginal people at risk of suicide. They include:

- renewing the NSW Aboriginal Mental Health and Wellbeing Policy;
- funding mental health projects through Aboriginal Community Controlled Health Services (ACCHS);
- funding drug and alcohol projects through ACCHS;

⁸³ Professor Dudgeon, [Transcript of evidence](#), 30 April 2018, p 4

⁸⁴ University of Western Australia, Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project, *Solutions that work: what the evidence and out people tell us*, November 2016. Accessed at: http://www.atsispep.sis.uwa.edu.au/_data/assets/pdf_file/0006/2947299/ATSISPEP-Report-Final-Web.pdf

⁸⁵ University of Western Australia, Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project, *Factsheet No 3: Suicide Prevention for Aboriginal and Torres Strait Islander young people*, p 2 accessed at http://www.atsispep.sis.uwa.edu.au/_data/assets/pdf_file/0007/2790925/Fact-Sheet-No.-3.pdf

⁸⁶ Submission 46, [NSW Government](#), p 20

- funding the adaptation of the *Getting on Track in Time – Got it!* program for Aboriginal communities. The *Aboriginal Got It!* program is a school-based program targeting Aboriginal children in kindergarten to year 2 to identify children's social and emotional difficulties. A four year trial of the program commenced in March 2018.⁸⁷

Committee comment

- 2.23 The Committee notes the continued overrepresentation of Aboriginal and Torres Strait Islander children and young people dying by suicide. The Committee is mindful of the multiple risk factors impacting this group of children and young people that place them at greater risk of suicide and considers a focused and ongoing whole of government approach is required to improve the health outcomes for these vulnerable children and young people.
- 2.24 The Committee acknowledges the programs in place presently to address the mental health and wellbeing of Aboriginal and Torres Strait Islander children. However, given the consistent overrepresentation of Aboriginal and Torres Strait Islander children and young people dying by suicide, the Committee considers that suicide prevention for this group needs to be prioritised by the NSW Government.
- 2.25 The Committee considers that the NSW Government needs to ensure there is ongoing commitment to the needs of this vulnerable group and recommends the NSW Government develop an Aboriginal and Torres Strait Islander specific youth suicide prevention plan for New South Wales consistent with the findings of the ATSIPEP study. The ATSIPEP study has provided useful research on what programs work for Aboriginal and Torres Strait Islander children and young people.

Recommendation 7

The Committee recommends that the NSW Government develop an Aboriginal and Torres Strait Islander specific youth suicide prevention plan for New South Wales consistent with the findings of the ATSIPEP study.

Young males

- 2.26 In their submissions both the CDRT and the NSW Government recognised that males have been consistently overrepresented in suicide deaths of children and young people in New South Wales. In fourteen of the last fifteen years the suicide rate for males has been higher.⁸⁸
- 2.27 The joint submission of Lifeline, batyr and Orygen also highlighted young men as a group in need of suicide prevention approaches suitable for them:
- ... while young males are almost three times as likely to die by suicide as young Australian females, only a small proportion of young men are accessing services or receiving appropriate treatment for their mental ill-health.

⁸⁷ Submission 46, [NSW Government](#), p 21. See also NSW Health, Child and Adolescent Mental health Services, *Getting on Track in Time – Got it!* accessed at <https://www.health.nsw.gov.au/mentalhealth/pages/camhs.aspx#gotit> on 10 September 2018

⁸⁸ Submission 45, [NSW Child Death Review Team](#), p 5; Submission 46, [NSW Government](#), p 19

... rather than continuing to offer more of the same in terms of service and treatment models for young men experiencing mental ill health, there is a real need for innovative new approaches to be developed and trialled, co-designed with young men themselves.

... In short, it means that services and programs must be relevant and accessible to those groups for who they are created. This is best achieved through co-design of services.⁸⁹

- 2.28 Some inquiry participants indicated that one issue relevant to young men is that they are not seeking help at the same rate as young women. The Advocate for Children and Young People commented:

Young females are more likely than young males to tell someone about a bullying problem. If children and young people do not tell, they said it was because they thought the bullying would get worse, that it would not help, that they were embarrassed, or they did not know who to approach.⁹⁰

- 2.29 Similarly, when discussing rates of contact to Kids Helpline, Ms Samantha Batchelor, Senior Researcher indicated that about 80 per cent of contacts come from females and that young females are more likely to seek help on any issue compared to young males.⁹¹

- 2.30 Jason Threthowan, Chief Executive Officer of headspace also commented on this issue indicating that male stereotypes are largely responsible for young men not seeking help:

A factor in suicide and males is, first of all, seeking help. I take the room back to what is getting in the way of a young man or a boy actually seeking help. In our work a lot of it comes back to stereotypes of males in generations gone by where boys were told to move on, suck it up, "You'll be right," and there was really not a safe place to express feelings, sadness, loneliness or helplessness. A follow-on effect we know about from previous studies is that 13 per cent of young men who needed to seek help were actually seeking help—that was a study in 2007.⁹²

- 2.31 The NSW Manager of headspace further commented on the initiatives being undertaken in schools and the broader community on improving young men's understanding of mental health, including professional learning for executives, principals and sports coaches and partnering with the National Rugby League to do postvention planning through football clubs in regional communities.⁹³

- 2.32 The NSW Chief Psychiatrist commented on the higher rates of suicide in young men and described the work and programs being implemented in schools to reduce stigma as being of great value:

Groups like beyondblue and the Black Dog Institute have normalised the conversation about mental health, distress and the risk of suicide. Those things take a generation

⁸⁹ Submission 34, [Lifeline, batyr and Orygen](#), p 6

⁹⁰ Mr Johnson, [Transcript of evidence](#), 12 February 2018, p 35

⁹¹ Ms Samantha Batchelor, Senior Researcher, yourtown (Kids Helpline), [Transcript of evidence](#), 5 March 2018, p 6

⁹² Mr Jason Threthowan, Chief Executive Officer, headspace, [Transcript of evidence](#), 5 March 2018, pp 26 - 27

⁹³ Ms Narelle Corless, NSW Manager, Statewide Services, headspace, [Transcript of evidence](#), 5 March 2018, p 27

to change; we cannot do it with a short, sharp program. I do not underestimate the potential value of that approach. Today's public discourse is dramatically different from the public discourse 15 years ago. There are programs targeting things that interest young men. Some sporting groups have specific programs directed at increasing conversations about wellbeing. They do not focus on suicide; rather, they focus on wellbeing. They try to put the conversation in the positive as opposed to the negative, and are framing it in terms of looking after one's health.

Committee comment

- 2.33 The Committee is concerned that a group of young people feel reluctant to seek help when they most need it. While the Committee acknowledges that stigma associated with seeking help for mental and emotional distress affects all children and young people, it appears to affect more young men.
- 2.34 The Committee accepts the evidence from the NSW Chief Psychiatrist, that finding a short and quick program designed to address longstanding stereotypes and beliefs is difficult.
- 2.35 In acknowledging that, the Committee considers that the NSW Government can assist in this area by continuing to support programs in schools, and increase its support for programs in the broader community, that are designed to promote help seeking behaviour and improve mental health awareness in young men.
- 2.36 The Committee also recommends that support be provided to research and consult with young men on what mental health services and programs they would access.

Recommendation 8

The Committee recommends that the NSW Government continues to support programs in schools, and increase its support for programs in the broader community, that are designed to promote help seeking behaviour and improve mental health awareness in young men.

Recommendation 9

The Committee recommends that the NSW Government provide support to research and consult with young men on what mental health services and programs they would access.

Children and young people living in regional, rural and remote areas

- 2.37 The CDRT submitted that over the 5 year period 2011 – 2015, 61 per cent of young people who died by suicide resided in major cities. However, the rate of suicide deaths in regional areas was higher than in major cities (1.64 compared to 1.03).⁹⁴
- 2.38 Professor Hazell reinforced this data at the public hearing and indicated that the reasons for the difference between metropolitan and regional areas are

⁹⁴ Submission No 45, [NSW Child Death Review Team](#), p 5. In their submission, the CDRT indicated that regional areas include outer and inner regional areas and exclude remote and very remote areas.

multifaceted. Professor Hazell urged that a minimum standard of clinical services, and access to those services, should be available in every part of New South Wales:

The CDRT data show clearly that young people from regional New South Wales are overrepresented in suicide death statistics. The reasons for that are probably multi-factorial and it is difficult to identify a specific single factor. It could be socioeconomic, access to means, ethnic mix, or religious- or faith-based issues. We do not know. However, I do think it points to a consideration of the level of clinical services, particularly mental health services, and access to those services for young people in regional New South Wales. I would advocate that we set a minimum standard of what is acceptable in terms of access to mental health care and ongoing care.⁹⁵

2.39 The University of New England submitted that for regional areas, services are either non-existent or some distance away. To address this, the University recommended that those in contact with young people be empowered to better understand risk factors and warning signs associated with youth suicide.⁹⁶

2.40 Grand Pacific Health, a provider of health and mental health services to South Eastern New South Wales communities, submitted that young people in regional and rural areas experience challenges including limited services, limited public transport and increased experiences of risk factors such as social disadvantage and educational opportunities.⁹⁷

2.41 For example, Ms Felicity Scott, Service Manager at headspace Maitland, suggested that distance and cost are the main barriers for young people accessing services in the Hunter region:

... But most of the reason that young people do not access [headspace] is that it is an hour and 15 minutes approximately by car. There is one train in and one train out that may or may not be suitable. We do have eight clients at the moment who come down from the Upper Hunter. They are certainly not in the mild-to-moderate space. Unfortunately ... they may only have 3.2 counsellors out of the number they were funded for, because the skillsets are not up there. ... That would not be the main reason young people do not access Maitland; it would be the travel—the resources and the cost.⁹⁸

2.42 Highlighting the need for flexibility when providing services to young people, Ms Clarinda Masters, Youth Support Officer at the Ungooroo Medical Service, reinforced concerns about distance being a significant barrier to access:

A young 17-year-old male, significant identified mental health issues and there are lots of barriers. That young person needed to get from Muswellbrook to Maitland and there are two trains a day, first thing in the morning and late at night. If they miss that train they cannot get to that appointment which then puts their support [and] access to service[s] back a significant amount.⁹⁹

⁹⁵ Professor Hazell, [Transcript of evidence](#), 12 February 2018, p 18

⁹⁶ Submission 10, [University of New England](#), p 2

⁹⁷ Submission 13, [Grand Pacific Health](#), p 1

⁹⁸ Ms Felicity Scott, [Transcript of evidence](#), 27 November 2017, p 32

⁹⁹ Ms Clarinda Masters, Youth Support Worker, Ungooroo Medical Service, [Transcript of evidence](#), 27 November 2017, p 5

2.43 In Lithgow, distance and a lack of local services were also identified as barriers to young people accessing psychological help:

Services can be complex and not available at the times people need them, especially for acute services. A number of so-called "Lithgow" services are in reality outreached from a service hub elsewhere, with limited opening hours and capacity. There is often a marked difference therefore between the official network of services and what people find on the ground, especially in a crisis. The level of services that people in larger centres take for granted are just not available here. So people either travel or go without, sometimes with devastating consequences.

There is no Headspace service providing early intervention mental health services for young people in Lithgow, with the nearest located in Bathurst (45 minutes by car) and Penrith (1.5 hours by car). Neither of these is readily accessible to young people.¹⁰⁰

2.44 Similarly, Youth Action commented on the many challenges facing children and young people living in regional, rural and remote areas including the availability of public transport and the costs associated with travel. Youth Action noted that some city councils were devising innovative solutions to assist children and young people to access programs and services.¹⁰¹

CASE STUDY: SHOALHAVEN STUDENT PATHWAYS PASS

Shoalhaven City Council partnered with schools, community groups and transport providers to produce a program called the Shoalhaven Student Pathways Pass. The program allows students to travel for free when travelling to approved school-centred, off-site learning activities, for example TAFE or work experience.

Source: Submission 52, [Youth Action](#), pp 15 - 16

2.45 ReachOut highlighted in their submission that they are conducting research on the help seeking behaviours of regional and rural young people. A survey of 400 rural and regional young people revealed that digital self-help services are critical to support young people's mental health and wellbeing. The survey indicated that the benefits of digital self-help services included:

- confidentiality and anonymity – in regional areas there is a feeling that everybody knows everybody;
- 24/7 support – the ability to access support when needed was considered important;
- scale – services in rural towns can be stretched so digital tools can often be where children and young people can get help; and

¹⁰⁰ Submission 6, [Lithgow City Council](#), p 3

¹⁰¹ Submission 52, [Youth Action](#), p 15

- autonomy – promotes children and young people to feel in control.¹⁰²

Committee comment

- 2.46 The Committee notes the higher rates of suicide for children and young people living in regional, rural and remote areas and is concerned about the multiple risk factors these children and young people may face.
- 2.47 As mentioned in Chapter One of the report, the Committee is encouraged by the trials underway of the LifeSpan model in regional areas. The Committee considers that these trials present an opportunity for these communities and health providers to evaluate what is available in regional, rural and remote areas, what is missing and what works.
- 2.48 As mentioned by many inquiry participants, while access to treatment is key to effective suicide prevention, this can be limited in regional, rural and remote areas. The level of clinical mental health services available in regional, rural and remote areas, coupled with access to those services, needs to be of an acceptable standard. To this end, the Committee recommends that the NSW Government set a minimum standard for the provision of and access to mental health services in regional, rural and remote New South Wales.
- 2.49 To provide further support to children and young people in regional, rural and remote areas, the Committee sees merit in exploring options similar to that undertaken by Shoalhaven City Council where children and young people can travel for free to approved school-centred activities. The Committee considers such an option could be expanded to include free travel to and from a health service in regional, rural and remote areas.
- 2.50 The Committee also acknowledges the evidence on enabling regional, rural and remote communities to be more aware of the risk factors and warning signs of youth suicide. In Chapter Five the Committee discusses gatekeeper training as a means for suicide prevention. Gatekeeper training is one of the strategies being delivered as part of the LifeSpan trial sites and its aims are to ensure that people who are in regular contact with children and young people are trained to respond sensitively and appropriately to the needs of children and young people in distress. This is important in regional, rural and remote areas where a child or young person may experience delays in accessing care. In Chapter Five the Committee recommends that gatekeeper training be implemented across New South Wales.

Recommendation 10

The Committee recommends that the NSW Government set a minimum standard for the provision of and access to mental health services in regional, rural and remote New South Wales, and fund the delivery of those services.

Recommendation 11

The Committee recommends that the NSW Government assist regional, rural and remote communities to build partnerships between local councils, health providers, community groups and transport providers to subsidise or eliminate

¹⁰² Submission 22, [ReachOut](#), pp 8 - 9

travel costs for children and young people travelling to or from an approved health service.

LGBTI young people

2.51 The Committee received evidence about the greater prevalence of suicide attempts and self-harm in the LGBTI community, in particular amongst young people. Twenty 10 submitted that LGBTI young people are five times more likely to attempt suicide and twice as likely to engage in self-injury than children and young people of a similar age.¹⁰³

2.52 For LGBTI young people, particularly transgender people, access to non-discriminatory and sensitive clinical support was considered a barrier to accessing assistance. Accessing non-judgmental and confidential mental health care can be even more difficult for young people who are both LGBTI and also live in rural and regional settings, or otherwise belong to multiple vulnerable groups.¹⁰⁴

2.53 ACON submitted that LGBTI communities are at higher risk and in need of tailored approaches for suicide prevention:

Suicide Prevention Australia has identified LGBT youth as being particularly vulnerable to suicide.¹⁰⁵

2.54 Youth Action also stated that the expectation of discrimination and abuse is one of the barriers to LGBTI young people seeking help:

One of the greatest barriers that LGBTI young people face is the expectation that they may experience the same types of discrimination or abuse that they face day-to-day when they reach out to a mental health program, professional or support service.¹⁰⁶

2.55 Similarly, Twenty10 said that increased risks of suicide and self-harm are 'directly related to experiences of stigma, prejudice, discrimination and abuse.'¹⁰⁷

2.56 In evidence before the Committee, Mr Terence Humphreys, Co-executive Director, Twenty10, commented:

There is lots of research that shows that young people do not feel safe. LGBTI young people do not necessarily feel safe contacting a mainstream support service. If they have contacted a service and they have experienced misunderstanding or judgement around their identity, they will not reach out for support again. Often they will not know about a service, particularly if they are in regional and remote areas. They are not able to use that. Certainly lots of schools limit people's ability to search on school-based computers and those sorts of things. Young people are scared of their families seeing their browser history, apps or searches on their phone.¹⁰⁸

¹⁰³ Submission 30, [Twenty10](#), p 2

¹⁰⁴ Ms Crystin Davies, Co-chair, Twenty10, [Transcript of evidence](#), 5 March 2018, p 18

¹⁰⁵ Submission 29, [ACON](#), p 4

¹⁰⁶ Submission 52, [Youth Action](#), p 18

¹⁰⁷ Submission 30, [Twenty10](#), p 3

¹⁰⁸ Mr Humphreys, Co-Executive Director, Twenty10, [Transcript of evidence](#), 5 March 2018, p 21

- 2.57 The Mental Health Carers NSW also discussed the high rate of suicidality for LGBTI young people and the need for specific suicide prevention services aimed at addressing stigma:

There is a need to develop more mental health programs and services that are designed to address stigma, discrimination, bullying, violence and other forms of marginalisation experienced by young LGBTI people which are known to increase the risk of suicide. Young transgender people especially have high rates of suicidality. Additionally, there is a specific need for more mental health crisis intervention services for this group that offer face-to-face service delivery as the majority of crisis services for young LGBTI people currently only offer assistance through telephone hotlines or online chats and forums.¹⁰⁹

Further research

- 2.58 In their submission the Black Dog Institute submitted there are gaps in research on effective suicide prevention programs for LGBTI young people:

Although the increased risk of suicide for young LGBTIQ people is widely acknowledged, one of the major gaps in evidence is in programs to prevent suicide for these young people. This should be an area of focus for research funding.¹¹⁰

- 2.59 Twenty 10 in their submission referred to the National LGBTI Mental Health and Suicide Prevention Strategy and its six recommended action areas. One action area relates to evidence, data collection and research with the aim of establishing an evidence base about LGBTI populations that represents their histories, lives, experiences, identities, relationships and accurate recordings of death by suicide.¹¹¹

Committee comment

- 2.60 The prevalence of suicide and self-harm among LGBTI young people is concerning to the Committee. The evidence that LGBTI young people do not feel safe asking for help for fear of judgment and discrimination is an area that needs addressing.
- 2.61 In Chapter One the Committee recommends that the NSW Government develop a youth specific suicide prevention plan. In order to address the specific issues relevant to LGBTI young people, the Committee recommends that the plan should refer to vulnerable and at risk children and young people, including LGBTI young people. The NSW Government should also consult with LGBTI young people during the development of the plan.
- 2.62 If a standalone youth specific suicide prevention plan is not adopted, then specific reference should be made to vulnerable and at risk children and young people in the Strategic Framework for Suicide Prevention in NSW 2018-2023..
- 2.63 The Committee also notes the lack of evidence on effective programs and services for LGBTI youth and considers this an important area for further research. Such

¹⁰⁹ Submission 49, [Mental Health Carers NSW](#), p 3

¹¹⁰ Submission 41, [Black Dog Institute](#), p 4

¹¹¹ Submission 30, [Twenty10](#), p 4

research should consult with LGBTI young people from regional, rural and remote areas, and metropolitan areas of New South Wales.

Recommendation 12

The Committee recommends that the NSW Government make specific reference to vulnerable and at risk children and young people in any youth suicide prevention plan and consults with vulnerable and at risk children and young people in its development.

Recommendation 13

The Committee recommends that the NSW Government support research into suicide prevention programs for LGBTI young people.

Recommendation 14

The Committee recommends that the NSW Government makes a request to NSW Health to undertake and publish a comprehensive international literature search of peer review research into what have been evaluated as the most successful suicide prevention programs for children and young people.

Chapter Three – Accessing services

- 3.1 This Chapter examines some of the barriers that children and young people in New South Wales face when trying to access clinical services that may assist in preventing suicide. It also explores how technology can be used to overcome some of these barriers.
- 3.2 The Chapter also highlights an area of concern relating to children and young people accessing care at emergency departments and the lack of continued care provided to them after discharge.
- 3.3 Lastly, the Chapter will also examine evidence on the importance of involving children and young people in the design of suicide prevention services.

Improving access to services

- 3.4 While there are many different non-clinical services that play an important role in suicide prevention, this section will examine the difficulties young people – and often their families – experience in accessing clinical services such as psychologists, counsellors, psychiatrists, and emergency departments.
- 3.5 A lack of access to clinical services was a major theme in this inquiry. The Committee heard that young people found it difficult to access services for several reasons, including:
- Lack of services – for young people who live in regional, rural and remote areas, often there were limited or no clinical services in their local area¹¹²
 - Distance – when services did exist within a region, they were sometimes located a significant distance from home¹¹³
 - Long waiting lists – young people found it difficult to get an appointment within a reasonable time, and sometimes had to wait up to 4 - 8 weeks to see a psychologist¹¹⁴
 - Cost – seeing a private psychologist or counsellor was sometimes not affordable¹¹⁵
 - Stigma – young people are sometimes scared to access services because of the stigma attached to mental health¹¹⁶

¹¹² Ms Scott, Service Manager, Headspace Maitland, [Transcript of evidence](#), 27 November 2017, p 32; Ms Geerin, Berdeen Town Coordinator, Where There's a Will, [Transcript of evidence](#), 27 November 2017, p 33

¹¹³ Ms Scott, [Transcript of evidence](#), 27 November 2017, p 32; Ms Geerin, [Transcript of evidence](#), 27 November 2017, p 33

¹¹⁴ Submission 1, [Miss Elizabeth Veasey](#), p 3; Submission 15, [Upper Hunter Where There's a Will](#), p 3; Ms Geerin, [Transcript of evidence](#), 27 November 2017, p 33

¹¹⁵ Ms Geerin, [Transcript of evidence](#), 27 November 2017, p 33

¹¹⁶ Ms Batchelor, Senior Researcher, yourtown (Kids helpline), [Transcript of evidence](#), 5 March 2018, pp 3 – 4; Dr Wright, NSW Chief Psychiatrist, NSW Ministry of Health, [Transcript of evidence](#), 5 March 2018, p 52

- 3.6 The Committee is aware of a current study commissioned by NSW Health which examines young people's experiences accessing and navigating health care in New South Wales, the *Access 3: young people's healthcare journeys* study (the Access 3 study).
- 3.7 The Access 3 study focuses on the experiences of vulnerable young people aged 12 – 24, including those who are Aboriginal and Torres Strait Islander, live in rural or remote areas, are homeless, or are gender and sexuality diverse. It involved a survey of 1,416 young people and in-depth interviews with 41 of those young people.
- 3.8 In February 2017, the Access 3 Preliminary Report was published. The Preliminary Report identified that cost was the most frequently cited barrier for accessing health services, with 45 per cent of young people saying this would prevent them from accessing a health service.¹¹⁷ The report also identified other barriers young people experienced when accessing health services.¹¹⁸

Would prevent me from visiting a health service:	%
Cost	45.6
Opening hours mean I need time off study or work	31.7
I would feel embarrassed	27.6
Difficulty getting there	22.8
I would have to ask my parents/ carers to take me	22.0
I would feel judged	20.1
The gender of the doctor/ health professional	18.8
I worry about confidentiality	16.2
I don't have my own Medicare card	12.2
I don't know which service/s to go to	11.7
Language or cultural reasons	5.9
Nothing	21.3

- 3.9 The Access 3 Preliminary Report highlighted a number of other key findings including:
- Young people were embracing technology when attempting to access and navigate health services, and technology presented a new opportunity to connect young people to services¹¹⁹
 - Young people often require support when navigating and attempting to access the health system¹²⁰
 - Young people want health care that is tailored to them, built on relationships of trust¹²¹

¹¹⁷ Robards F, Kang M et al, February 2017, [Access 3: young people's healthcare journeys: Preliminary report](#), p 10

¹¹⁸ Robards F, Kang M et al, February 2017, [Access 3: young people's healthcare journeys: Preliminary report](#), p 10

¹¹⁹ Robards F, Kang M et al, February 2017, [Access 3: young people's healthcare journeys: Preliminary report](#), pp 14 - 17

¹²⁰ Robards F, Kang M et al, February 2017, [Access 3: young people's healthcare journeys: Preliminary report](#), p 17

¹²¹ Robards F, Kang M et al, February 2017, [Access 3: young people's healthcare journeys: Preliminary report](#), p 19

- Stigma and even discrimination were significant barriers to healthcare faced by young people, particularly marginalised groups of young people¹²²

3.10 The Access 3 Preliminary Report appears to reflect the evidence received by the Committee regarding the main barriers faced by children and young people when accessing clinical support.

3.11 However, the Committee received varying evidence as to what was the most significant barrier faced by young people when accessing mental health services. The main barriers cited by various inquiry participants, particularly in the context of children and young people in regional, rural and remote areas, included distance, cost and a lack of social services.

Committee comment

3.12 Young people who are in distress or need help should be able to access appropriate clinical care in a timely manner. However, the evidence received by the Committee as detailed in Chapters Two and Three suggest that those young people who are in the greatest need of help may face multiple barriers to accessing clinical support.

3.13 Although they may vary for different groups, the main barriers for young people accessing clinical support appear to be cost, distance, and a lack of local services. Long waiting lists – likely compounded by a lack of services - also prevent young people from accessing necessary support.

3.14 The Committee acknowledges that the stigma attached to mental health issues remains an obstacle to some young people seeking help. Stigma may be more pronounced for particular groups, such as trans young people, who may sometimes be subject to discriminatory or unhelpful treatment when attempting to access clinical support.

Improving continuity of care

3.15 The Committee was concerned to receive evidence indicating that children and young people are not receiving adequate follow-up care in the period following discharge from care for a previous suicide attempt.

Post-discharge care

3.16 Studies indicate that the highest risk period to die by suicide is in the first three months following an attempt.¹²³ In its submission Orygen noted that recently published research found that:

- A small majority of people did not receive any follow-up care from a community mental health service within 30 days of being discharged from hospital.

¹²² Robards F, Kang M et al, February 2017, [Access 3: young people's healthcare journeys: Preliminary report](#), p 20

¹²³ Submission 51, [Beyond Blue](#), p 4

- For those who had not previously been connected with a community health care service the results were even lower, with less than one third receiving care.¹²⁴

3.17 Orygen indicated that this is a national issue requiring urgent attention:

This is an urgent national issue, as identified by the Australian Government, and not restricted to NSW only. Orygen commends the recent \$750,000 investment by the NSW Government to extend the Way Back Support Service in Newcastle after evaluation. Providing a similar investment to roll out this model across all Local Hospital Networks in NSW should be considered.¹²⁵

3.18 The Way Back Support Service is a suicide prevention service developed by Beyond Blue. It delivers non-clinical care and support after a suicide attempt. Support Coordinators link people into existing health, clinical and community-based services, to assist people to access the community-based support that is available after a suicide attempt.¹²⁶

3.19 The Service Manager for the Way Back Support Service – Hunter Primary Care commented on what the goal of the Way Back Support Service is and detailed what support is provided:

Our goal is to encourage people to connect with services, to follow up on what the recommendations are from the hospital and to help them link in with services—act as advocates and encourage them to get to their GP, help link in with psychologists, housing, domestic violence services, whatever is needed for that person, and also provide support and encouragement.

What it looks like on the ground is primarily phone support. We do meet face to face if needed, but the majority of people are happy with the phone, and that allows us to see an average of 48 referrals a month. It is primarily phone support, checking in, hearing their story, providing support and encouragement, and helping link in then advocating the services or following up. We connect with the GP throughout if they have a nominated GP. Someone has described it as reverse Lifeline. We are assertive. We try to make contact within one working day of discharge from hospital. We make multiple attempts. They have an identified support once they are linked in.¹²⁷

3.20 The Way Back Support Service is currently available in three locations in New South Wales; the Hunter, Murrumbidgee and North Coast regions. The Committee notes that in May 2018, the Commonwealth Government committed \$37.6 million to expand the Way Back Support Service nationally and Beyond Blue is contributing a further \$5 million.¹²⁸

3.21 The National Mental Health Commission (NMHC) also commented on the importance of post discharge care and noted that this issue was raised by them in

¹²⁴ Submission 19, [Orygen](#), p 6

¹²⁵ Submission 19, [Orygen](#), p 6

¹²⁶ Submission 51, [Beyond Blue](#), p 27

¹²⁷ Ms Adams, Service Manager, The Way Back Support Service – Hunter Primary Care, [Transcript of evidence](#), 27 November 2017, p 18

¹²⁸ Media release, [Beyond Blue welcomes suicide prevention funding announcement](#), 8 May 2018. See also NSW Ministry of Health, [Answers to supplementary questions](#), 12 September 2018, p 4

their 2014 report, *Contributing Lives, Thriving Communities - the National Review of Mental Health Programmes and Services*. The NMHC stated that assertive follow up care is required during the high risk period and supported the Fifth Plan's call for 'health services to aim for zero suicides within health care settings.'¹²⁹

3.22 The Child Death Review Team (CDRT) submitted that their work in reviewing child deaths has consistently identified issues and opportunities for improvement in the provision of mental health supports. Such improvements include the need for assertive follow up, particularly in circumstances where the young person indicates a reluctance or refusal to engage with therapeutic support.¹³⁰

3.23 The joint submission from Lifeline, batyr and Orygen also indicated that the period following discharge from care after a previous suicide attempt carries a very high risk for suicide or further attempts. Lifeline, batyr and Orygen submitted that it is critical that step-down care is provided and that this care is appropriate and acceptable for children and young people. They submitted:

Again, mobile apps, online supports and chat services (such as Lifeline) are important, as are assertive and followed up referrals to youth mental health services. The Way Back Support Service in Newcastle is a promising initiative being trialled and funded by the NSW Government, the Movember Foundation and Beyond Blue with other trials currently underway in the Northern Territory and the ACT.¹³¹

3.24 Dr Fiona Shand, Senior Research Fellow and Research Director, LifeSpan, Black Dog Institute, also commented on post-discharge care as being an important factor in people's risk of reattempting suicide:

We must ensure that if discharge planning is put in place it is followed through. That does not always happen. We are now seeing a rollout of services like the Way Back Support Service in the Illawarra. A range of other services are being rolled out to ensure that care is being provided once a person is discharged from hospital. The international evidence suggests that that makes a big difference to people's risk of reattempting suicide.¹³²

3.25 The NSW Government outlined NSW Health's governance arrangements and accountabilities for mental health and suicide prevention. The NSW Government indicated that there are nine mental health specific Key Performance Indicators (KPIs) which are monitored by the Ministry and within the local health districts (LHD). One of the KPIs concerns post-discharge care: Acute Post-Discharge Community Care - follow up within seven days (per cent).¹³³ In its submission the NSW Government commented that:

Continuity of care (follow up and support by professionals and peers) in the community settings for psychiatric patients discharged from a hospital leads to an improvement in symptoms severity, readmission rate, level of functioning and patient assessed quality of life. Early and consistent follow up in the community reduces

¹²⁹ Submission 12, [National Mental Health Commission](#), pp 2 - 3

¹³⁰ Submission 45, [NSW Child Death Review Team](#), p 11

¹³¹ Submission 34, [Lifeline, batyr and orygen](#), p 5

¹³² Dr Shand, Senior Research Fellow and Research Director, LifeSpan, Black Dog Institute, [Transcript of evidence](#), 5 March 2018, p 13

¹³³ Submission 46, [NSW Government](#), p 12

suicide among hospital discharged mental health patients with high suicide risk and history of self-harm.¹³⁴

- 3.26 The Deputy Secretary, Ministry of Health, expanded on the KPI during evidence before the Committee:

That KPI is part of the service agreements the ministry has with the local health districts. They are agreed annually and there is a focus on ensuring that the performance around a range of different areas is monitored over time. The KPI for post-discharge follow-up is an important component of the transition from acute care into the community space. It is monitored through reports from local health districts and speciality health networks, and it has been in place for a number of years.¹³⁵

- 3.27 With regard to what follow-up within seven days involves for a child or young person, the Ministry of Health explained that the indicator measures whether a person has contact with a public mental health service in the seven days after discharge. Contact with mental health teams anywhere in New South Wales are included and telephone and videoconference contact is included where the person is directly involved. Contact with private practitioners, GPs or non-government services are not included as the data is unavailable to the health system.¹³⁶

- 3.28 In the current 2017-18 Service Agreement between the Secretary and the Local Health Districts the target for performance of the Acute Post-Discharge Community Care KPI is 70%.¹³⁷The Ministry of Health provided the Committee with a breakdown of the KPI results for individuals aged between 10 and 24 years over a four year period:¹³⁸

Year	Rate of post-discharge follow up care
2016/17	69.3%
2015/16	65.8%
2014/15	64.9%
2013/14	62.4%

- 3.29 In a response to supplementary questions, the Ministry of Health provided a further breakdown of the KPI results by LHD for individuals under 18 years. For this

¹³⁴ Submission 46, [NSW Government](#), p 12

¹³⁵ Dr Lyons, Deputy Secretary, Strategy and Resources, Ministry of Health, [Transcript of evidence](#), 5 March 2018, p 52

¹³⁶ NSW Ministry of Health, [Answers to supplementary questions](#), 12 September 2018, p 1

¹³⁷ See: <https://www.health.nsw.gov.au/Performance/Documents/service-agreement-generic.pdf>

¹³⁸ NSW Ministry of Health, [Answer to questions taken on notice](#), 29 March 2018, p 1. The Ministry of Health noted that the indicator is not broken down by age, so it is not possible to determine the performance measure in relation to 12 to 25 year olds.

group the state-wide rate of follow up care for the years 2016-17 and 2017-18 exceeded the target of 70 per cent.¹³⁹

- 3.30 For those LHDs that did not reach the target, the Ministry of Health noted that the reasons suggested for this included: the challenges presented by children and young people being admitted outside their LHD; as well as children and young people refusing contact within the timeframe.¹⁴⁰
- 3.31 In response to why the target is not set higher than 70 per cent, the Ministry of Health provided the following reasons:
- follow-up care with private psychiatrists, psychologists, GPs or non-government organisations cannot be measured because the data is unavailable to the health system. For some children and young people these services might be the preferred form of follow-up care;
 - the majority of people being discharged are voluntary patients at the time of discharge and some young people and their families refuse follow-up care from New South Wales health services;
 - follow-up care cannot be measured for interstate or overseas residents who return home after discharge.¹⁴¹

Committee comment

- 3.32 The evidence received on post discharge care was concerning for the Committee, particularly given that this appears to be an ongoing issue. The Committee accepts that NSW Health is aware of the importance of post discharge care and is encouraged that there are performance indicators to monitor this issue. However, the Committee considers this needs to be an immediate focus of the NSW Government.
- 3.33 The Committee considers that there should be little reason as to why the KPI for follow up care within seven days is not consistently met. The Committee notes the reasons provided for some areas not meeting the target. However, the Committee considers this is a critical service area and NSW Health should prioritise strategies to continually improve post discharge care for children and young people, especially children and young people who show reluctance and resistance to receiving care.
- 3.34 The Committee welcomes the recent announcement by the Commonwealth Government of funding to expand the Way Back Support Service nationally. The expansion of a service like the Way Back Support Service should be beneficial on a number of levels, including providing care and practical support to individuals, support for existing health and community services and additional data. However, it is still important that the NSW Government ensures that clinical support services in the community are able to provide appropriate and timely post-discharge care.

¹³⁹ NSW Ministry of Health, [Answers to supplementary questions](#), 12 September 2018, p 2

¹⁴⁰ NSW Ministry of Health, [Answers to supplementary questions](#), 12 September 2018, p 2

¹⁴¹ NSW Ministry of Health, [Answers to supplementary questions](#), 12 September 2018, p 3

Recommendation 15

The Committee recommends that NSW Health prioritises strategies to improve post discharge care for children and young people, especially children and young people who show reluctance to receiving care.

Using technology to enhance access to services

3.35 Much evidence was received on the emerging role of technology in improving mental health and providing access to services. The Committee heard that Australia is a leader in the area of e-mental health:

I think we have made some great advances here in Australia around e-mental health. We are ahead of the game internationally in our e-mental health approaches.¹⁴²

3.36 Ms Sharnie Everton, Suicide Prevention Officer at the Hunter New England Primary Health Network, agreed:

Australia is the lead on e-therapy resources, and I have conducted e-therapy resource training up in the New England area as well for the GPs up there... There are different e-therapy tools for different age groups and different types of professions.¹⁴³

3.37 The Committee received evidence on the many different types of technology-based tools that can be used in the context of suicide prevention. These include apps (some of which link to psychological support), web-based forums, web-based chats with a counsellor or psychologist, text-based chat, telepsychology, telepsychiatry and videopsychology services.

3.38 Well-established organisations such as Kids Helpline, Lifeline and ReachOut already harness technology when delivering mental health services to young people. Kids Helpline and Lifeline generally rely on telephone and online counselling services, while ReachOut provides moderated web forums and a variety of online apps.

3.39 That said, many witnesses recognised that there was greater scope for technology to provide appropriate mental health treatment and support to young people.¹⁴⁴

3.40 The Committee heard about some of these new opportunities to reach people in distress. For instance, Ms Everton talked about the work of the primary health network (PHN) in promoting the use of e-therapy tools, particularly for GPs and practice nurses:

I have conducted e-therapy resource training up in the New England area as well for the GPs up there, because some of them do not know about them or they are not really sure how they work. There are different e-therapy tools for different age groups

¹⁴² Ms Skehan, Director, Everymind, [Transcript of evidence](#), 27 November 2017, p 11

¹⁴³ Ms Everton, Suicide Prevention and Early Intervention Officer, Hunter New England Central Coast Primary Health Network, [Transcript of evidence](#), 27 November 2017, p 16

¹⁴⁴ Dr Robinson, Senior Research Fellow, Orygen, [Transcript of evidence](#), 12 February 2018, pp 41, 46; Mr Nicholas, Chief Executive Officer, Reach Out Australia, [Transcript of evidence](#), 12 February 2018, p 49; Dr Shand, [Transcript of evidence](#), 5 March 2018, p 11; Mr Woodward, Executive Director, Lifeline Research Foundation, [Transcript of evidence](#), 5 March 2018, p 7

and different types of professions. Some people prefer a cartoon while some people prefer to look at photos of people, and there are different interventions.

... They [the e-therapy tools] are coming from different universities. They are coming from Black Dog. Some of them are Australian government run ... There are different sorts and there is a whole wealth of apps programs available to people. Some also have psychologists that ring up each time a module is completed, so they can have a talk on the phone with a psychologist. Most of them are free. The reason why the Government is pushing these e-therapy resources is that it frees up the psychologists and psychiatrists for people who really do need them, instead of the people who just have mild anxiety and can have some therapy through a device instead.¹⁴⁵

- 3.41 In its submission, the Black Dog Institute recommended that telepsychology and telepsychiatry be used in conjunction with web-based services to support people beyond their initial call for help:

In addition, e-health services, telepsychology and tele-psychiatry may provide some alternative input. Extending the Lifeline model of crisis intervention so that it includes evidence-based web programs to support people beyond their initial call for help has been successful in trials. We recommend that this model be trialled more extensively, including with Kids Helpline and potentially linking in resources from ReachOut, Headspace online, and other youth-appropriate e-health services.¹⁴⁶

- 3.42 The use of telehealth services generally was supported by the Royal Australian New Zealand College of Psychiatrists (RANZCP), which suggested that these services could supplement access to psychiatrists and other mental health professionals in rural and remote communities. RANZCP also suggested that such technology could be used to reach young people in urban areas who face 'non-geographic' barriers to accessing psychiatric help.¹⁴⁷

- 3.43 The Committee also received evidence on the use of telepsychiatry in emergency departments, which will be discussed later in this Chapter.

- 3.44 The Committee heard that there are many advantages to using technology to reach young people who are seeking help or otherwise in distress. For instance, Dr Buhagiar, Director of Service Delivery at ReachOut, identified the main advantages of e-mental health as anonymity and privacy, more flexible hours, the ability to overcome physical distance, and also the capacity to provide young people with a sense of autonomy:

... What we find with our programs is that young people are accessing them when other services are not open, so evenings, weekends and those sorts of times, so that they can respond immediately.

... The benefits that young people tell us about online services is the anonymity and privacy, so they do not necessarily want to expose themselves and the distress they are going through to people they know or do not know, in particular.

¹⁴⁵ Ms Everton, [Transcript of evidence](#), 27 November 2017, p 16

¹⁴⁶ Submission 41, [Black Dog Institute](#), p 4

¹⁴⁷ Submission 54, [Royal Australian New Zealand College of Psychiatrists](#), p 7

... One of the most important aspects of that is that young people are constantly telling us that they want to have a sense of control and a sense of autonomy in terms of the way that they access help, when they access help and how they access help.

... The beauty of online is that there are no boundaries and young people, provided they have an internet connection—and now 98 or 99 per cent of homes have an internet connection—or a young person has a smart phone in their pocket, those barriers and the divide are broken down in terms of accessing services that are perhaps not available in rural and regional areas.

... There are a lot of benefits in terms of the services that we are offering, and we know that young people are using them¹⁴⁸

- 3.45 However, the Committee also heard that a challenge for e-mental health was improving its ability to link young people to face-to-face support:

The other challenge that we see is smoothing out the pathways to further support.... The question for us is: How can we most efficiently and effectively move those young people [who do not get better after contacting ReachOut] on to further services? That is really about better integrating the digital world with the offline world, so that a young person in a rural area we can geolocate using mobile data so that it only pops up with services if you live in Griffith. But we actually need the mapping of those services at a local health district [LHD] level so that we know where that young person can go. ... Better integrating digital services where the young person is getting help is the real challenge.¹⁴⁹

- 3.46 This evidence appeared to echo the Black Dog Institute's recommendation that there be further trials of evidence-web based programs which supported people beyond their initial call for help to a crisis intervention hotline like Lifeline.
- 3.47 The Committee heard that there is evidence to suggest that treatment provided online to adults is just as effective as face-to-face treatment.¹⁵⁰ However, the Committee was not made aware of any studies which have found that this is also the case in young people.
- 3.48 In addition, the Committee notes that Orygen's *Raising the Bar for Youth Suicide Prevention* report said that there is limited research evidence on youth-specific online suicide interventions. However, it also referred to some evidence which suggests that online suicide prevention programs improved help-seeking attitudes, and that cognitive behaviour therapy delivered online appeared to decrease suicidal ideation.¹⁵¹

Committee comment

- 3.49 In light of the many barriers that children and young people may face when seeking help, the Committee was heartened to hear of the wide range of e-therapy and technology tools available to young people. When used appropriately, the

¹⁴⁸ Dr Kerrie Buhagiar, Director of Service Delivery, ReachOut, [Transcript of evidence](#), 12 February 2018, pp 49 - 50

¹⁴⁹ Mr Nicholas, Transcript of evidence, [12 February 2018](#), pp 52 - 53

¹⁵⁰ Dr Shand, Transcript of evidence, [5 March 2018](#), p 11

¹⁵¹ Orygen: National Centre of Excellence in Youth Mental Health, [Raising the bar for youth suicide prevention](#), 2016, p 36

Committee believes that technology can overcome many or at least some of the barriers to young people accessing clinical services – including distance, cost and stigma.

- 3.50 While e-mental health is an area of great opportunity, the Committee notes that the use of technology such as telepsychology and videopsychology may not be appropriate in all cases, and should not be seen as a substitute for face-to-face services. However, where there may be significant barriers to accessing services, and those barriers may be difficult to practically resolve, the provision of technology such as telepsychology and videopsychology may assist in overcoming these obstacles.
- 3.51 In this context, the Committee notes the evidence received from the Black Dog Institute that the 'Lifeline model of crisis intervention', which involves using 'evidence-based web programs to support people beyond their initial call for help' should be trialled more extensively and linked in with existing youth organisations such as Kids Helpline, Reach Out and headspace.¹⁵² Such trials may also assist in providing further evidence about the efficacy of online suicide interventions aimed at young people.
- 3.52 For these reasons, the Committee has recommended that the NSW Government investigate opportunities to use technology, such as telepsychology, videopsychology and web-based programs, to provide clinical support to children and young people in regional, rural and remote areas who may find it difficult to access a face-to-face service.

Recommendation 16

The Committee recommends that the NSW Government investigate opportunities to use technology, such as telepsychology, videopsychology and web-based programs, to provide clinical support to children and young people in regional, rural and remote areas who may find it difficult to access a face-to-face service.

Use of telepsychiatry in emergency departments

- 3.53 The Committee received evidence to suggest that some emergency departments, particularly in regional, rural and remote areas, did not have the necessary skills or capacity to conduct psychiatric assessments. This sometimes resulted in young people travelling between emergency departments in regional, rural and remote areas or not having appropriate follow-up care after being discharged.¹⁵³ However, Dr Nagarsekar, Clinical Director, Child and Adolescent Mental Health Service, highlighted that telepsychiatry – the provision of psychiatric services via telephone to emergency departments - was one way of addressing this gap:

For the Upper Hunter there is the Northern Mental Health Emergency Care – Rural Access Program that provides telepsychiatry to emergency departments, for example at Muswellbrook hospital and they can link up young people to appropriate follow-up in the community once they are discharged from the emergency department. There

¹⁵² Submission 41, [Black Dog Institute](#), p 4

¹⁵³ Dr Bala Nagarsekar, Clinical Director, Child and Adolescent Psychiatrist, Child and Adolescent Mental Health Service, [Transcript of evidence](#), 27 November 2017, p 20

is a child psychiatrist that is on-call 24/7. There is one child psychiatrist from 8.30 until 5.00 and another after hours. A lot of the children and adolescents who present to ED, following an assessment, do get discussed with the child psychiatrist who is on call who then gives them advice on management and follow-up in the community.¹⁵⁴

- 3.54 Established in August 2016, the Northern Mental Health Care - Rural Access Program to which Dr Nagarsekar referred is a pilot program operating in Muswellbrook, Kempsey, Grafton and Byron Bay. The program uses video conferencing technology to provide emergency departments with 24 hour access to advice from child psychiatrists. Those child psychiatrists may also assist in conducting mental health assessments and organising follow-up care.¹⁵⁵
- 3.55 The Committee is also aware of a similar telepsychiatry program which was trialled some years ago in Western New South Wales, known as the Mental Health Emergency Care – Rural Access Program.¹⁵⁶

Committee comment

- 3.56 Telepsychiatry is a way to improve the access of children and young people in regional, rural and remote areas to specialist psychiatric expertise. In particular, telepsychiatry may help regional, rural and remote health professionals in emergency departments better care for their patients in circumstances where there is limited psychiatric expertise available on the ground.
- 3.57 To help address ongoing issues of access in regional, rural and remote areas, the Committee has recommended that the NSW Government consider expanding telepsychiatry services such as the Northern Mental Health Emergency Care – Rural Access Program to more emergency departments across the State, particularly in regional, rural and remote areas.

Recommendation 17

The Committee recommends that the NSW Government consider expanding telepsychiatry services such as the Northern Mental Health Emergency Care – Rural Access Program to more emergency departments across the State, particularly in regional, rural and remote areas.

The response rate for counselling and crisis support lines

- 3.58 Kids Helpline currently employs 110 tertiary-qualified professional counsellors who answer calls and respond to online contacts from children and young people.¹⁵⁷ As discussed above, Kids Helpline is an example of an existing service that harnesses technology to provide counselling and crisis support to children and young people who may be in distress.

¹⁵⁴ Dr Nagarsekar, [Transcript of evidence](#), 27 November 2017, p 25

¹⁵⁵ NSW Health, [Northern Mental Health Emergency Care Rural Access Program \(24/7 Telehealth\)](#).

¹⁵⁶ NSW Government and Agency for Clinical Innovation, [How Access Has Changed Emergency Mental Health Care in the Bush](#), viewed 17 September 2018

¹⁵⁷ Ms Batchelor, [Transcript of evidence](#), 5 March 2018, p 3

- 3.59 yourtown, which administers Kids Helpline, described the advantages of this kind of teleweb service:

Kids Helpline provides a unique safety net for vulnerable children and young people. By promoting itself as 'there for anyone at any time about anything', and offering the option to remain anonymous, Kids Helpline casts a wide net and seeks to reduce the effect of stigma on help-seeking. Being a virtual service, it is accessible from any geographical location, by any young person with access to a phone or internet connection. Being 24/7, it enables young people to seek help at a time and from a place that suits them.

... Through its youth-friendly no wrong door approach, Kids Helpline routinely fills service system gaps including a chronic lack of after-hours support, difficulty fitting emerging symptoms into mental health service eligibility criteria, fragmented pathways from child to adult mental health services, a lack of face-to-face services in some areas, and the high cost of much mental health care.¹⁵⁸

- 3.60 Kids Helpline performs a number of roles. In addition to general counselling, counsellors educate children in targeted psychotherapeutic interventions (such as cognitive behavioural therapy), liaise with other services (such as schools and child protection services), and respond to children in crisis. Where appropriate, Kids Helpline then assists children and young people to access specialist face-to-face services.¹⁵⁹

CASE STUDY: KIDS HELPLINE

Kids Helpline is a national 24/7 telephone and online counselling service for five to 25 year olds seeking support on a wide range of issues.

In 2017 more than 113,000 attempts to contact Kids Helpline were made by children and young people in New South Wales, but Kids Helpline counsellors were only able to respond to 58 per cent of these attempted contacts.

Source: Ms Batchelor, Transcript of evidence, 5 March 2018, p 3

- 3.61 Although Kids Helpline is a national service, more than one third of contacts (37 per cent) from children and young people in 2012 – 2016 came from New South Wales.¹⁶⁰
- 3.62 However, the Committee received evidence that of the 113,000 attempts made by children and young people in New South Wales to contact Kids Helpline in 2017, only 58 per cent of those attempts at contact received a response. The Committee did not receive evidence about the reasons these contacts were unsuccessful. However, the Committee heard that for the children in New South Wales who

¹⁵⁸ Submission 32, [yourtown](#), p 5

¹⁵⁹ Submission 32, [yourtown](#), p 18

¹⁶⁰ Submission 32, [yourtown](#), p 3

successfully made contact each week, 50 sought counselling in relation to suicide.¹⁶¹

- 3.63 The Committee also heard that the NSW Government provides no funding to Kids Helpline.¹⁶²

Committee comment

- 3.64 There are many established and reputable technology-based services, such as Lifeline, Kids Helpline, ReachOut, and QLife, which provide counselling and crisis support to individuals in need, or link those individuals to appropriate professional support. In particular, Kids Helpline, ReachOut and eheadspace are services focused on children and young people.
- 3.65 The Committee heard concerning evidence that while a significant number of children and young people from New South Wales attempt to contact Kids Helpline each year (e.g. 113,000 contacts in 2017), only about 58 per cent of these contacts are answered. Many of the children and young people who do make contact sought counselling in relation to suicide.
- 3.66 Given that many children and young people from New South Wales try to contact Kids Helpline but have their calls unanswered, the Committee concludes that as a consequence some children and young people may not be receiving the help they need. Further, the lack of a timely response may cause some children and young people to give up seeking help.
- 3.67 However, the Committee did not receive evidence on why many of those who contacted Kids Helpline were unsuccessful, or whether those children successfully contacted Kids Helpline on a subsequent occasion. The Committee also did not receive evidence on the response rates of other youth-focused services such as ReachOut and eheadspace.
- 3.68 Noting the important role that such non-government services have in responding to children and young people in New South Wales who need help, the Committee has recommended that the NSW Government may wish to consider providing funding to such services to improve their response rates.

Recommendation 18

The Committee recommends that the NSW Government consider providing funding to youth-focused services like Kids Helpline, ReachOut and eheadspace to improve the response rate to contacts from children and young people in New South Wales.

Co-design of services by young people

- 3.69 Many inquiry participants emphasised the need for suicide prevention services to be co-designed with young people:

¹⁶¹ Ms Batchelor, [Transcript of evidence](#), 5 March 2018, p 3

¹⁶² Ms Batchelor, [Transcript of evidence](#), 5 March 2018, p 3

yourtown strongly believes that young people are the experts in their own lives and it is essential that their views are used to inform the design and delivery of sustainable and effective services to support them.¹⁶³

3.70 The evidence suggested that the 'co-design' of services also meant involving young people in the development, implementation and evaluation of such services.¹⁶⁴

3.71 For Aboriginal and Torres Strait Islander children and young people, the Committee learnt that it is particularly important that services are co-designed to incorporate cultural and lived experience elements:

"A common success factor in community-based interventions or responses to Indigenous suicide is their development and implementation through Indigenous leadership and in partnership with Indigenous communities. This is not only because responses need to address cultural and 'lived experience' elements, but also because of the right of Indigenous people to be involved in service design and delivery as mental health consumers."¹⁶⁵

3.72 Services delivered to vulnerable groups may especially benefit from co-design.¹⁶⁶

3.73 By co-designing services with children and young people, the Committee heard that such services were more likely to be successful:

Most critically, children and young people must be involved in the development of policies and practices that affect them. They must be included in the design, implementation and monitoring of all the programs that the Committee has heard about during this inquiry. Their insight into these issues is critical, and in my opinion significantly increases the likelihood of success.¹⁶⁷

3.74 Orygen agreed that co-designing services would most likely improve the efficacy of those services 'at reducing suicide and suicide-related behaviours among young people.'¹⁶⁸

Committee comment

3.75 The Committee shares the view of many inquiry participants that suicide prevention services should be co-designed with children and young people, especially vulnerable and at-risk groups. Where possible, 'co-design' should mean involving these children and young people in the development, implementation

¹⁶³ Ms Batchelor, [Transcript of evidence](#), 5 March 2018, p 3; see also Mrs Brogden, Co-Chair, National Mental Health Commission, [Transcript of evidence](#), 12 February 2018, p 29; Submission 12, [National Mental Health Commission](#), p 1; Submission 19, [Orygen](#), p 2; Submission 34, [Joint submission, Lifeline \(Australia\), batyr and Orygen](#), p 3; Submission 48, [Mission Australia](#), pp 3, 14, 20

¹⁶⁴ Submission 21, [Suicide Prevention Collaborative – Illawarra Shoalhaven](#), p 2; Mr Johnson, Advocate for Children and Young People, [Transcript of evidence](#), 12 February 2018, p 36

¹⁶⁵ Submission 8, [Aboriginal Child Family and Community Care Secretariat](#), citing Dudgeon, P., Milroy J., et al (2016) Solutions that work: What the evidence and our people tell us, [Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project Report](#), p 2

¹⁶⁶ Submission 21, [Suicide Prevention Collaborative – Illawarra Shoalhaven](#), p 2

¹⁶⁷ Mr Johnson, [Transcript of evidence](#), 12 February 2018, p 36

¹⁶⁸ Submission 19, [Orygen](#), p 2

and evaluation of suicide prevention services in order to promote the accessibility and efficacy of such services.

Chapter Four – Improving data collection

- 4.1 This Chapter focuses on data: its importance, collection and use. Reliable and timely data helps government and non-government organisations to make informed decisions about youth suicide and its prevention.
- 4.2 The Chapter will summarise the current data on youth suicide and outline how data is collected in New South Wales. It will also identify current challenges in data collection and examine possible solutions, including the creation of a suicide register and a multi-centre sentinel system for measuring rates of self-harm.

Current data on youth suicide, attempted suicide and self-harm

- 4.3 During this inquiry, the Committee received differing evidence regarding the incidence of youth suicide in New South Wales. Such differing evidence highlights the complexity of suicide and the importance of accurate data collection.
- 4.4 Some submissions and witnesses suggested that more children and young people in New South Wales and Australia were taking their own lives each year.¹⁶⁹ Others suggested that there was no statistically significant increase in the rate of youth suicide.¹⁷⁰
- 4.5 Some witnesses observed that, while suicide among children and young people was of great concern, overall rates were declining, and other older age groups were much more likely to die by suicide.¹⁷¹
- 4.6 However, in 2017, the number and rate of suicide deaths of children under 18 in New South Wales was the highest in 20 years. Mr Michael Barnes, the NSW Ombudsman and Convenor of the NSW Child Death Review Team (CDRT), observed that this was particularly significant because there has been a continual decline in the rate of child deaths over that same period. Unlike most other causes of death, suicides among children have not reduced.¹⁷²
- 4.7 The CDRT also found that, in 2015, suicide was the leading cause of death for 15 – 17 year olds. This was the second highest mortality rate for that age group since 1997.¹⁷³

¹⁶⁹ Submission 19, [Orygen: the National Centre of Excellence in Youth Mental Health](#), p 1: 'An analysis of ABS and coronial suicide data over the past 10 years indicates that suicide rates among young people have been increasing'; Dr Robinson, Senior Research Fellow, Orygen, [Transcript of evidence](#), 12 February 2018, p 41; Submission 23, [Federation of Parents and Citizens Association](#), pp 4-5: '...suicide rates...have climbed within the last ten years.'

¹⁷⁰ Submission 45, [CDRT](#), p 4: in relation children under age 18 years; Mr Barnes, NSW Ombudsman and Convenor of the NSW Child Death Review Team, [Transcript of evidence](#), 12 February 2018, p 16; Professor Hazell, Independent Member, NSW Child Death Review Team, [Transcript of evidence](#), 12 February 2018, p 18; Submission 46, [NSW Government](#), p 6, citing a 2015 Child Death Review Team report.

¹⁷¹ Ms Skehan, Director, Everymind, [Transcript of evidence](#), 27 November 2017, p 9; Submission 11, [NSW Mental Health Commission](#), p 6

¹⁷² Mr Barnes, [Transcript of evidence](#), 12 February 2018, p 16; Professor Hazell, [Transcript of evidence](#), 12 February 2018, p 18

¹⁷³ CDRT, October 2017, [NSW Child Death Review Team Annual Report 2016-17](#), p 5

- 4.8 Suicide has also been the leading or second-leading cause of death for 10 – 14 year olds in New South Wales since 2012, although the overall numbers are small.¹⁷⁴
- 4.9 Despite the somewhat differing evidence on rates of youth suicide, the Committee received consistent evidence that more children and young people were self-harming¹⁷⁵ and that self-harm is likely to be more prevalent than is currently suggested.¹⁷⁶ Dr Murray Wright, NSW Chief Psychiatrist, said:
- The short answer is that the figures we collect have to be seen as an underestimate and as a not very reliable approximation of the extent of self-harm in the community.¹⁷⁷
- 4.10 Although the relationship between self-harm and suicide is complex,¹⁷⁸ those who self-harm generally appear to be at greater risk of suicide.¹⁷⁹

The importance of data

- 4.11 Many inquiry participants emphasised the importance of collecting data on suicide, suicide attempts and self-harm. At the hearing, Mr Barnes summarised the importance of data:
- Accurate, reliable and standardised data in relation to suicide and suicide attempts is necessary for a number of reasons, including: to understand the extent and cost of suicide and self-harm; to target research effectively; and to develop appropriately targeted intervention and postvention strategies.¹⁸⁰
- 4.12 Many suggested that properly capturing such data was essential to constructing a profile of suicide risk in New South Wales. Without data, it is also difficult to measure the impact of suicide prevention programs and appropriately target funding.¹⁸¹ Some also observed that data was needed to identify potential or existing suicide clusters, which are more common in young people.¹⁸²

¹⁷⁴ Submission 45, [CDRT](#), p 5

¹⁷⁵ See Submission 11, [NSW Mental Health Commission](#), p 6; Submission 19, [Orygen: the National Centre of Excellence in Youth Mental Health](#), p 1: '...data from the Australian Institute of Health and Welfare show rates of hospitalisation for young women aged 15 – 19 for self-poising have increased dramatically';

¹⁷⁶ Orygen: The Centre of Excellence for Youth Mental Health, 2016, [Looking the other way: young people and self-harm](#), pp 4 – 5

¹⁷⁷ Dr Wright, New South Wales Chief Psychiatrist, [Transcript of evidence](#), 5 March 2018, p 53

¹⁷⁸ Dr Wright, [Transcript of evidence](#), 5 March 2018, p 52; Professor Hazell, [Transcript of evidence](#), 12 February 2018, p 19

¹⁷⁹ Submission 11, [NSW Mental Health Commission](#), p 6; Submission 19, [Orygen: the National Centre of Excellence in Youth Mental Health](#), p 8; Professor Hazell, [Transcript of evidence](#), 12 February 2018, p 23

¹⁸⁰ Mr Barnes, [Transcript of evidence](#), 12 February 2018, p 16

¹⁸¹ Submission 11, [NSW Mental Health Commission](#), p 6; Submission 19, [Orygen: the National Centre of Excellence in Youth Mental Health](#), p 8; Submission 21, [Suicide Prevention Collaborative: Illawarra and Shoalhaven](#), p 2; Submission 32, [YourTown](#), p 19; Ms Douglas, National Manager, headspace Schools Support, [Transcript of evidence](#), 5 March 2018, p 29

¹⁸² Submission 12, [National Mental Health Commission](#), p 7; Submission 19, [Orygen: the National Centre of Excellence in Youth Mental Health](#), pp 1 and 7

Current data collection methods

Data collection in New South Wales

- 4.13 When a child or young person dies by a suspected suicide in New South Wales, that death must be reported to the State Coroner.¹⁸³
- 4.14 While most deaths do not proceed to inquest, the Coroner will undertake an investigation into the cause of death. This may involve obtaining a brief of evidence from the police which usually includes the police report, medical records, post mortem and pathology reports, and sometimes statements from witnesses such as family and friends.
- 4.15 The Coroner inputs necessary information into the National Coronial Information System (NCIS). This is a national database maintained by a board of management comprising coronial and public health representatives. The Australian Bureau of Statistics (ABS) then uses information in the NCIS database to determine the cause of death for statistical purposes.
- 4.16 If a child under 18 dies, their death will also be reported to the CDRT.
- 4.17 In contrast, data relating to self-harm and suicide attempts is not routinely captured. There is some data which records hospital admissions for self-harm, but such data may not be reliable as it does not include presentations of self-harm which are made to emergency departments, general practitioners and non-government organisations.

Data collected by the Australian Bureau of Statistics

- 4.18 Like all states and territories, information regarding deaths by suicide is recorded in the NCIS. This information comes from various sources, including police, toxicologists, pathologists and coroners.¹⁸⁴
- 4.19 The ABS relies on NCIS data or death certificates to help code underlying causes of death.¹⁸⁵ The underlying cause of death identifies the intent and mechanism of the death. Related causes of death - for example, the existence of a mental health condition - may also be recorded.¹⁸⁶
- 4.20 The accuracy of a cause of death depends on the completeness and timeliness of information available on the NCIS. At the hearing, the ABS gave evidence that most information is obtained from the police, autopsy and toxicology reports, rather than coronial findings:

In New South Wales it is taken probably in the main from the police, the autopsy and the toxicology reports, and between those sources of information you have a very rich

¹⁸³ [Coroners Act 2009](#), s 6. This section defines 'reportable death' to include violent or unnatural deaths, sudden deaths the cause of which is unknown and deaths under suspicious or unusual circumstances.

¹⁸⁴ Submission 44, [Australian Bureau of Statistics](#), p 3

¹⁸⁵ Submission 44, [Australian Bureau of Statistics](#), pp 2-3

¹⁸⁶ Submission 44, [Australian Bureau of Statistics](#), pp 4-5

picture of what actually happened. The coroner's findings are generally quite limited unless a death goes to inquest. We will work with whatever we have.¹⁸⁷

- 4.21 The Committee received evidence from the Coroner to suggest that, compared to other jurisdictions, coronial findings in New South Wales on suicide deaths are quite limited, even for deaths that do not proceed to inquest.¹⁸⁸
- 4.22 The ABS can still record that a death was an act of intentional self-harm if a coroner makes an open finding. However, if a coroner makes a finding of intent – for example, that the death was the result of a car accident - the ABS data will reflect that finding.¹⁸⁹ The ABS has acknowledged that due to a lack of evidence as to intent the coroner may record a death as an accident in cases where the death may actually have been an act of intentional self-harm (i.e. a suicide).¹⁹⁰
- 4.23 Due to the reliance on police reports, the Committee understands that the NCIS has worked with police nationwide to try and standardise as well as enhance the quality of information collected on police forms.¹⁹¹
- 4.24 To ensure timely data, coding of deaths often has to occur in the presence of incomplete NCIS records.¹⁹² The ABS seeks to maximise accuracy by publishing a preliminary cause of death dataset eight months after the end of a statistical year, and then revising that data over a further two years as new information emerges.¹⁹³
- 4.25 The Committee heard evidence that the ABS is conducting a pilot where it captures additional psychosocial information in its suicide dataset. Examples of such psychosocial factors include relationship breakdowns, family violence, bullying, contact with police or time in prison.¹⁹⁴ The Committee heard about the value of such contextual information:

I think moving into things like psychosocial factors – at the moment that work is effectively experimental...It would then be a couple of years before we could determine how well it can measure trends over time, in terms of changes and factors. But the reality is, at the moment people are very much reliant on individual studies maybe looking at only one factor at a time. If we are already working with this information, and we can find a way to capture it as we go through the process of

¹⁸⁷ Mr Eynstone-Hinkins, Director, Australian Bureau of Statistics (ABS), [Transcript of evidence](#), 12 February 2018, p12

¹⁸⁸ Ms Butler, Manager, Domestic Violence Death Review Team, NSW Coroner, [Transcript of evidence](#), 12 February 2018, p 2

¹⁸⁹ Mr Eynstone-Hinkins, [Transcript of evidence](#), 12 February 2018, p 13

¹⁹⁰ Mr Eynstone-Hinkins, [Transcript of evidence](#), 12 February 2018, p 13

¹⁹¹ Mr Eynstone-Hinkins, [Transcript of evidence](#), 12 February 2018, p 15

¹⁹² Submission 44, [Australian Bureau of Statistics](#), p 3

¹⁹³ Submission 44, [Australian Bureau of Statistics](#), p 3 and see also Mr Eynstone-Hinkins, [Transcript of evidence](#), 12 February 2018, p 11.

¹⁹⁴ Mr Eynstone-Hinkins, [Transcript of evidence](#), 12 February 2018, p 11; see also submission 44, [Australian Bureau of Statistics](#), p 5. The Committee understands from the information accompanying [ABS' latest data release](#) that it will publish psychosocial information relating to the 2017 data at a later date.

looking just at what the self-harm is there, then I think this could become a very useful resource.¹⁹⁵

- 4.26 The ABS indicated that it will seek to influence the forthcoming International Classification of Diseases (ICD-11) so that such information is captured. The Committee understands that a version of ICD-11 was released on 18 June 2018.¹⁹⁶

Data collected by the NSW Child Death Review Team

- 4.27 Established in 1996, the NSW Child Death Review Team (CDRT) maintains a register of the deaths of all children up to age 17 years. The register records a cause of death and demographic criteria which assist in identifying trends and steering the direction of research into any gaps.¹⁹⁷
- 4.28 The CDRT, through the NSW Ombudsman, has powers to compel agencies and individuals to provide information relevant to its functions. The register therefore includes information from NSW Health, the Coroner, the Department of Family and Community Services (FACS), and non-government agencies.¹⁹⁸
- 4.29 The CDRT will conclude that a death is a suicide if the Coroner finds that the death was self-harm with fatal intent. It can also find that a death was suicide if the Coroner has not finalised the matter, or has made an open finding, and there are other records which indicate a suicide.¹⁹⁹ However, reviews of deaths generally only occur once all other investigations are complete.²⁰⁰
- 4.30 The CDRT's review findings are published in its annual reports, and also in the Ombudsman's biennial reports of reviewable child deaths.²⁰¹

Hospital admissions data

- 4.31 NSW Health maintains administrative datasets of diagnoses using the International Classification of Diseases (ICD). The ICD does not distinguish between self-harm and attempted suicide.²⁰²
- 4.32 HealthStats NSW is an interactive, web-based application which can provide data about hospital admissions for self-harm and suicide rates for people over 15 years. However, this data does not include people who presented to emergency but were not admitted, or people who do not present to hospital following self-harm.²⁰³
- 4.33 The NSW Government submission conceded that emergency departments are likely to substantially under-record presentations of self-harm, and therefore the

¹⁹⁵ Mr Eynstone-Hinkins, [Transcript of evidence](#), 12 February 2018, p12

¹⁹⁶ World Health Organization, [Classifications](#), viewed 18 September 2018

¹⁹⁷ Submission 45, [NSW Child Death Review Team \(CDRT\)](#), p 2

¹⁹⁸ Submission 45, [CDRT](#), p 2

¹⁹⁹ Submission 45, [CDRT](#), p 3

²⁰⁰ Submission 45, [CDRT](#), pp 2-3

²⁰¹ For example, see CDRT, October 2017, [NSW Child Death Review Team Annual Report 2016-17](#); NSW Ombudsman, June 2017, [Reports of Reviewable Deaths 2014 and 2015: Child Deaths, Volume 1](#).

²⁰² Submission 46, [NSW Government Submission](#), p 29

²⁰³ Submission 46, [NSW Government Submission](#), pp 6 and 29

Ministry of Health is exploring strategies to promote more accurate data collection in emergency departments.²⁰⁴

Local data arrangements

- 4.34 The National Mental Health Commission (NMHC) gave evidence that some data may be captured unofficially at the local level. For example, police, ambulance, the local Lifeline or suicide prevention group may maintain a spreadsheet of data on suicides and episodes of self-harm in their community. The NMHC acknowledged that this was not an optimal method of data collection.²⁰⁵

Other sources

- 4.35 Other sources of data, particularly self-harm data, may be derived through the Australian Trauma Registry (ATR).²⁰⁶ The ATR was established by the National Trauma Research Institute, a collaboration between Monash University and Alfred Health in 2012.²⁰⁷ The ATR collates data on type of injury, treatment received and discharge status from 26 major hospitals in Australia.²⁰⁸

Challenges for data collection

- 4.36 The problems with existing data collection processes was a recurring theme during this inquiry. The Committee heard that data on suicide and suicide-related behaviours is collected inconsistently, is not shared between organisations and is often not publically available.²⁰⁹ In addition, data on suicide, suicide attempts and self-harm is not timely.²¹⁰
- 4.37 The challenges associated with data on suicide deaths and self-harm are different, because these types of data are collected differently.
- 4.38 Data relating to suicide deaths in New South Wales may be subject to delays. For instance, Orygen suggested that there was a delay of up to two years in the availability of suicide death data in Australia.²¹¹ There was also some suggestion that under-resourcing of the Coroner's Court means that both the timeliness and quality of data relating to suicides is compromised.²¹² This is compounded by delays in government agencies providing necessary information (including the coronial brief) to the Coroner.²¹³

²⁰⁴ Submission 46, [NSW Government Submission](#), p 29

²⁰⁵ Mrs Brogden, Co-chair, National Mental Health Commission, [Transcript of evidence](#), 12 February 2018, p 33

²⁰⁶ Submission 12, [National Mental Health Commission](#), p 6

²⁰⁷ National Trauma Research Institute, [Australian Trauma Quality Improvement Program and the Australian Trauma Registry](#), viewed 13 August 2018

²⁰⁸ Monash University, [Australian Trauma Registry](#), viewed 27 August 2018.

²⁰⁹ Submission 12, [National Mental Health Commission](#), p 6; Submission 28, [University of Wollongong: School of Psychology](#), p 9

²¹⁰ Submission 19, [Orygen: the National Centre of Excellence in Youth Mental Health](#), p 2; Submission 21, [Suicide Prevention Collaborative: Illawarra and Shoalhaven](#), p 2; Submission 34, [Joint submission from Lifeline Australia, batyr, and Orygen](#), p 7

²¹¹ Submission 19, [Orygen: the National Centre of Excellence in Youth Mental Health](#), p 8

²¹² Ms Butler, [Transcript of evidence](#), 12 February 2018, p 2; NSW Coroner's Court, [Answers to questions taken on notice](#), p 1

²¹³ NSW Coroner's Court, [Answers to questions taken on notice](#), p 1

- 4.39 In turn, delays at the state level are likely to reduce the timeliness and quality of ABS data, given that the ABS relies on data which is entered into the NCIS by state coroners.²¹⁴
- 4.40 In contrast, there appears to be no systematic collection of self-harm and suicide attempt data in New South Wales, and indeed nationally.²¹⁵ The CDRT suggested that this was an issue for particular attention.²¹⁶ Similarly, Dr Robinson of Orygen commented that self-harm data needed to be better captured:
- ... we are not investing well in data collection and monitoring...one of the best indicators of suicides and whether we are making any inroads in suicide prevention is the use of self-harm data. At the moment we are not collecting that very well nationally. That does not really make us different from a lot of other countries. There are a few pockets of excellent practice ... But we have not got a robust and reliable system for monitoring self-harm presentations to hospitals. That is where we think some opportunities lie in really understanding what is happening when it comes to self-harm presentations and how we might intervene.²¹⁷
- 4.41 Other submissions emphasised the importance of collecting self-harm and suicide attempt data. Such data can assist in identifying trends, particularly at a regional level, and can also inform targeted early interventions.²¹⁸
- 4.42 In evidence before the Committee, the NSW Government acknowledged that collecting accurate data on self-harm is an area which warrants attention.²¹⁹ As emergency departments are likely to substantially under-record presentations of self-harm,²²⁰ the Ministry of Health is exploring strategies to promote more accurate data collection.²²¹
- 4.43 The NSW Government also recognised the importance of the relationship between data on self-harm and suicide:
- Information on the numbers of people who die by suicide after contact with a health service following a suicide attempt requires (i) accurate identification of self-harm, (ii) access to timely data on causes of death and (iii) processes for ongoing linkage of these datasets.²²²
- 4.44 The NSW Mental Health Commission (NSW MHC) observed that the lead agencies in the LifeSpan trial sites were attempting to solve data problems by 'conducting

²¹⁴ Ms Butler, [Transcript of evidence](#), 12 February 2018, p 2; NSW Coroner's Court, [Answers to questions taken on notice](#), p 1

²¹⁵ Submission 21, [Suicide Prevention Collaborative: Illawarra and Shoalhaven](#), p 2; Submission 32, [YourTown](#), p 5; Submission 34, [Joint submission from Lifeline Australia, batyr, and Orygen](#), p 7

²¹⁶ Submission 45, [CDRT](#), pp 15-16

²¹⁷ Dr Robinson, [Transcript of evidence](#), 12 February 2018, pp 41 - 42

²¹⁸ Submission 32, [YourTown](#), p 20; Submission 41, [Black Dog Institute](#), p 5

²¹⁹ Dr Lyons, Deputy Secretary, Strategy and Resources, NSW Ministry of Health, [Transcript of evidence](#), 5 March 2018, p 52; Dr Wright, [Transcript of evidence](#), 5 March 2018, pp 52 – 53

²²⁰ See also Dr Shand, Senior Research Fellow and Research Director, LifeSpan, Black Dog Institute, [Transcript of evidence](#), 5 March 2018, p 16

²²¹ Submission 46, [NSW Government Submission](#), p 29

²²² Submission 46, [NSW Government](#), p 29

data audits and entering into local data-sharing arrangements.¹²²³ In this context, the NSW MHC noted that it has been exploring the creation of a suicide register with the NSW Coroner, which it suggested would build and expand on the data collection work begun in the LifeSpan trial sites.²²⁴ The Committee will examine the creation of a suicide register and other opportunities to improve data collection below.

Opportunities to improve data collection in New South Wales

Establishing a suicide register in New South Wales

- 4.45 A suicide register is a database of information relating to suicide deaths. This database may record a broad array of demographic, psychosocial and other information that helps provide context to a suicide death.
- 4.46 Victoria and Queensland both have suicide registers. In 2016 and 2017, South Australia and Tasmania both announced that they would establish a suicide register.²²⁵ Western Australia has also established an enhanced coronial information system for suicide.²²⁶
- 4.47 Mr Barnes, the NSW Ombudsman, in his capacity as the Convenor of the CDRT, recommended that the NSW Government consider establishing a suicide register.²²⁷
- 4.48 Other inquiry participants supported the creation of a suicide register in New South Wales.²²⁸
- 4.49 Without specific reference to a suicide register, other organisations also encouraged the government to establish a central database to collate suicide-related data from a range of sources.²²⁹
- 4.50 Similarly, the School of Psychology at the University of Wollongong supported uniform data aggregation, and repeated calls for a national suicide register in order to better understand underlying trends.²³⁰
- 4.51 The NSW Ombudsman explained the purpose of a suicide register:

The purpose of the register is to gather far more information than is available at any other source. The ABS simply records the fact of the medical cause of the death – fall

²²³ Submission 11, [NSW Mental Health Commission](#), p 6

²²⁴ Submission 11, [NSW Mental Health Commission](#), p 6

²²⁵ [South Australian Suicide Prevention Plan 2017 – 2021](#), p 21; [Tasmania Suicide Prevention Strategy \(2016 – 2020\)](#), pp 6,11

²²⁶ See National Coronial Information System, [Annual Report 2015 – 16](#), pp 3, 8

²²⁷ Mr Barnes, [Transcript of evidence](#), 12 February 2018, p 17. Until recently, Mr Barnes was the NSW Coroner, and before that was the Queensland Coroner.

²²⁸ Submission 11, [NSW Mental Health Commission](#), p 6; Submission 19, [Orygen: The National Centre of Excellence in Youth Mental Health](#), p 8; Mr Barnes, [Transcript of evidence](#), 12 February 2018, p 21; Ms Butler, [Transcript of evidence](#), 12 February 2018, p 3; Commissioner Lourey, Commissioner, NSW Mental Health Commission, [Transcript of evidence](#), 12 February 2018, p 31

²²⁹ Submission 16, [The Jack Luck Foundation](#), p 8; Submission 32, [YourTown](#), p 5; Submission 42, [Australian College of Mental Health Nurses](#), p 13

²³⁰ Submission 28, [University of Wollongong: School of Psychology](#), p 9

from height, drug overdose, asphyxiation – and the manner of death: intentionally self-inflicted external cause. A suicide register seeks to flesh out the picture and find as much as possible about the individuals – education history, medical history, previous self-harming episodes. It depends on how you design the register...²³¹

4.52 In the context of the Queensland suicide register, the NSW Ombudsman described the rich data profile which could be created in relation to a suicide death:

In partnership with the Coroner's office there, they have access to not just the Coroner's records but all other linked medical records, police records and education records. Indeed, they have direct access to family members if the family members are willing to provide that. So it enables a much richer data field to be created around the individual deaths.²³²

4.53 Mr Barnes stated that both the Victorian and Queensland suicide register receive such information in real time and start analysing this data before the Coroner makes a finding.²³³

4.54 At the hearing, Dr Nigel Lyons, Deputy Secretary, Strategy and Resources at the NSW Ministry of Health suggested that New South Wales did not require a suicide register as child deaths were already extensively reviewed. That said, he suggested that any register-like function could be undertaken by the CDRT.²³⁴

Suicide registers in other jurisdictions

4.55 The most established suicide registers in Australia are based in Victoria and Queensland. The Victorian and Queensland registers are administered by the Coroner and Griffith University respectively. The table below compares these registers, highlighting their similarities and key features:

	QLD ²³⁵	VIC ²³⁶
OPERATOR	Australian Institute for Suicide Research and Prevention, Griffith University	Coroners Prevention Unit, Coroners Court of Victoria
DATE CREATED	1992	2009
DATA SOURCES	Police reports, post-mortem records, toxicology reports, health records, coronial brief, interviews by police with family and friends	Police reports, post-mortem records, toxicology reports, health records, coronial records, interviews by police with family and friends

²³¹ Mr Barnes, [Transcript of evidence](#), 12 February 2018, p 21

²³² Mr Barnes, [Transcript of evidence](#), 12 February 2018, p 21

²³³ Mr Barnes, [Transcript of evidence](#), 12 February 2018, p 22

²³⁴ Dr Lyons, [Transcript of evidence](#), 5 March 2018, p 51

²³⁵ See Australian Institute for Suicide Research and Prevention, Griffith University, [Suicide in Queensland: Mortality Rates and Related Data 2011 – 2013](#), March 2016, Chapter 1.

²³⁶ See Sutherland, G., Milner, A. et al, [Implementation and evaluation of the Victorian Suicide Register](#), *Australian and New Zealand Journal of Public Health*, 42(3), 18 October 2017.

INFO RECORDED	Death and demographic details; medical history; interpersonal and situational stressors (e.g. relationship breakdown, relationship conflict, financial problems, bereavement, familial conflict, pending unemployment).	Death and demographic details; medical history; legal and welfare contacts before death; interpersonal and situational stressors (e.g. domestic and family violence, financial stressors, substance use).
METHODOLOGY	Coroner provides data. Cross-checked against NCIS data for closed cases only.	Coroner provides data.
CLASSIFICATIONS	Beyond reasonable doubt, probable and possible	Found to be a suicide if coronial finding of suicide, or open coronial finding and evidence suggests suicide.
TIMING	Data collection and analysis in real time, before Coroner makes findings. Register updated weekly, reports published for 3-year intervals	Data collection and analysis in real time, before Coroner makes findings.

4.56 Both Queensland and Victoria also have bodies which perform an equivalent role to that of the CDRT, as well as a suicide register.²³⁷

4.57 There is comparatively limited information available about the recently-announced registers in South Australia, Western Australia and Tasmania. However, the West Australian Coronial Suicide Information System (WACSIS), as it is known, appears to operate as part of the WA Coroner's Court Local Case Management System as an enhancement to the existing database. In 2015-16, the Telethon Kids Institute commissioned the NCIS to develop the WACSIS.²³⁸

Establishing a suicide mortality review team in New South Wales

4.58 Establishing a suicide mortality review team was also proposed as a way to improve the quality of data collected. For instance, Ms Anna Butler of the NSW Coroner's Court suggested that New South Wales should create a suicide mortality review team within the court which is modelled on the existing Domestic Violence Death Review Team (DV Death Review Team).²³⁹ Ms Butler manages the DV Death Review Team that sits in the NSW Coroner's Court and conducts in-depth reviews of domestic violence deaths in New South Wales.

4.59 The functions of the DV Death Review Team are as follows:

- a) to review closed cases of domestic violence deaths occurring in New South Wales,
- b) to analyse data to identify patterns and trends,

²³⁷ These are the Queensland Family & Child Commission and the Victorian Commission for Children and Young People.

²³⁸ National Coronial Information System, [Annual Report 2015 – 16](#), p 8

²³⁹ Ms Butler, [Transcript of evidence](#), 12 February 2018, pp 1 - 2

- c) to make recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths,
 - d) to establish and maintain a database about such deaths,
 - e) to undertake, alone or with others, research that aims to prevent or reduce the likelihood of such deaths.²⁴⁰
- 4.60 The DV Death Review Team may select the cases it wishes to review and publishes review reports every 2 years.²⁴¹ Notably, the DV Death Review Team may review a death even though it is or may be subject to action by the CDRT.²⁴²
- 4.61 Although suicide deaths are said to comprise more than 10 per cent of all deaths reported to the Coroner each year, most of those matters do not proceed to inquest. While other jurisdictions may provide a more detailed explanation of the death when deciding to dispense with an inquest, Ms Butler said that in New South Wales the Coroner's comments are generally quite brief.²⁴³
- 4.62 Through its emphasis on qualitative, rather than quantitative, analysis of information relating to a death, Ms Butler suggested that the suicide mortality review team could have many benefits:
- As the work of my team demonstrates, the death review process acts as a lens into systems and affords a critical and impartial analysis of the effectiveness of those systems—where improvements need to be made or where services do not reach. This process enhances our understanding of systemic issues both within individual cases and when looking across cases collectively. It provides critical insights that guide system reform and the development of targeted prevention initiatives. Put simply, to learn from a person's death you have to investigate, seek to understand and critically examine the person's life—their intersection with systems and services, their engagement with community and other support networks and their help seeking behaviours.²⁴⁴
- 4.63 The Committee also received evidence that the development of a suicide mortality review team may enhance inter-jurisdictional information and, in turn, improve the national reporting of suicide data.²⁴⁵

Committee comment

- 4.64 It is clear from the evidence received that stakeholders understand and support the accurate data collection of suicide deaths. The Committee acknowledges the efforts of the ABS in recent years to continually improve its data collection processes relating to suicide.

²⁴⁰ [Coroners Act 2009](#) (NSW), s 101F(1)

²⁴¹ [Coroners Act 2009](#) (NSW), ss 101H and 101J(1)

²⁴² [Coroners Act 2009](#) (NSW), s 101F(2)

²⁴³ Ms Butler, [Transcript of evidence](#), 12 February 2018, p 2

²⁴⁴ Ms Butler, [Transcript of evidence](#), 12 February 2018, p 2

²⁴⁵ Ms Butler, [Transcript of evidence](#), 12 February 2018, p 2

- 4.65 However, the Committee considers that there are clear areas for improvement. The Committee is recommending a suicide register for New South Wales. This would follow the examples set by Victoria and Queensland and, more recently, Western Australia, South Australia and Tasmania.
- 4.66 The Committee also recommends that the NSW Government consider establishing a suicide mortality review team. This would be informed by the existing DV Death Review Team model.
- 4.67 There are two main problems relating to collecting data on suicide deaths in New South Wales. Firstly, the publication of data on suicide deaths is delayed. Secondly, such data does not currently identify psychosocial and other factors which may assist in understanding a suicide.
- 4.68 In addressing these problems, an appropriately-designed register is likely to assist governments and other interested parties to better understand suicide. In conjunction with a suicide mortality review team, this would help improve the understanding of what prevention strategies are effective and where future interventions should be targeted.
- 4.69 The Ministry of Health gave evidence that a suicide register is not required in New South Wales. To the extent that such a register is required, the Ministry suggested that the CDRT could undertake this function. However, the Committee notes that the CDRT only has jurisdiction to investigate deaths of children up to 17 years old. Those who recommended a register seemed to recommend a suicide register tasked with whole-of-population surveillance.
- 4.70 Of course, the utility of any register will depend on its design. Although the Committee heard about the Queensland and Victorian registers, the Committee did not receive detailed evidence such that it feels able to propose a particular model. That said, the Committee suggests that there are some key features of an effective suicide register.
- 4.71 A suicide register should collect and analyse data in as close to real-time as possible. It should also provide an appropriate level of access to that information to government and, if appropriate, non-government agencies.
- 4.72 The suicide register should draw on rich data sources, such as police reports, medical records (including hospital records) and interviews with friends and family. For deaths involving children and young people, the register should also have timely access to child protection records, juvenile justice records and education records.
- 4.73 While delays within the Coroner's Court may compromise the timeliness of NCIS data, the Committee also received evidence that delays in the preparation of a coronial brief by the NSW Police Force may compound delays. For this reason, ideally the register should have direct or earlier access to information which often forms part of a coronial brief, such as health and police records. In any event, the timely completion of coronial briefs would likely assist in promoting the accuracy of register data.

- 4.74 In establishing a register, the NSW Government may also wish to work with the NSW Police Force to review the forms used in relation to suicide deaths. While there is no evidence to suggest that existing forms are deficient, taking the opportunity to review the forms would assist in ensuring that police records yield high-quality information that is aligned with the objectives of the register.
- 4.75 Whether the ABS is successful in influencing the next revision of ICD-11 such that psychosocial factors are coded may impact on the existence and design of a New South Wales register. The Committee's view is that in such circumstances a state-based suicide register would still be useful. This is because a state-based register may be better placed to work with state agencies, including the Coroner's Court, to promote the timely provision of relevant information.
- 4.76 The Committee received some evidence on the benefits of a suicide mortality review team. The Committee agrees that establishing such a team, in conjunction with a register, may have significant benefits.
- 4.77 This type of review function may be appropriately undertaken by a team which also sits within the body that administers the suicide register. Noting that the administrator of the Queensland Suicide Register periodically publishes detailed reports on trends in suicide deaths,²⁴⁶ the body administering any New South Wales-based suicide register may be able to perform a similar review of suicide deaths.
- 4.78 However, the Committee envisages that the suicide mortality review team would draw extensively on the model of the Domestic Violence Death Review Team. That team sits within the NSW Coroner's Court and conducts detailed reviews and analyses of domestic violence deaths in New South Wales with a view to making recommendations to government and conducting research to prevent or reduce the likelihood of deaths. It reports to Parliament every two years.
- 4.79 Although the CDRT already reviews the suicide deaths of children less than 17 years, the Committee notes that the DV Death Review Team is still able to review deaths that are or may be subject to action by the CDRT.
- 4.80 While the Committee acknowledges that its inquiry is focused on children and young people aged 12 to 24, the Committee is of the view that whole-of-population surveillance is a desirable goal, particularly for children and young people. For example, when talking about the high level of suicide in the community generally, Ms Douglas, National Manager at headspace School Support said, 'the more exposed young people are, the more they have learned knowledge of this behaviour.'²⁴⁷
- 4.81 The Committee does not envisage that the suicide mortality review team should duplicate the work of the CDRT. However, the Committee considers that the team should be able to select any death for review if it deems it appropriate in the circumstances, therefore operating in the same way as the DV Death Review Team

²⁴⁶ For instance, see Potts, B. and Kolves, Kairi et al, Australian Institute for Suicide Research and Prevention, Griffith University, [Suicide in Queensland: Mortality Rates and Related Data 2011 – 2013](#), March 2016.

²⁴⁷ Ms Kristen Douglas, National Manager, headspace School Support, Transcript of evidence, 5 March 2018, p 31

- 4.82 For these reasons, the Committee is of the view that the NSW Government should consider establishing a suicide mortality review team to review suicide deaths in New South Wales.

Recommendation 19

The Committee recommends that the NSW Government establish a suicide register in New South Wales.

Recommendation 20

The Committee recommends that the NSW Government consider establishing a suicide mortality review team to review suicide deaths in New South Wales.

Systematic data collection of suicide-related behaviours

- 4.83 During the inquiry, a recurring theme was that data collection on self-harm and suicide attempts required improvement.²⁴⁸
- 4.84 In response to this problem, Orygen advocated for the establishment of a linked sentinel system.²⁴⁹ A linked sentinel system is generally a hospital-based ongoing monitoring system which collects detailed clinical and demographic information from police, ambulance officers and emergency departments in relation to self-harm and suicide attempts. At the hearing, Dr Robinson, Orygen, discussed the value of such a system:
- The idea of a real-time sentinel site would enable us to spot suicide attempt clusters as they are emerging. In the same way that you have other types of disease or public health sentinel systems, you would be able to spot a problem as it is occurring rather than two years later when somebody sits down and analyses the data.
- The idea of having a multi-site system is that you have got bigger numbers so you are better powered to detect change, identify trends and those sorts of things, but it will also give you a strong epidemiological picture of what is occurring across the country.²⁵⁰
- 4.85 In this way, a linked sentinel system may enhance the availability of real-time data and better capture the suicide risk profile of an area or age group in order to identify and implement specific targeted prevention programs at an earlier date. This data may also help to evaluate the impact of government policies, programs, and local responses on the rate of suicide, attempted suicide and self-harm.²⁵¹

²⁴⁸ For example, see Dr Lyons, [Transcript of evidence](#), 5 March 2018, p 52; Dr Wright, [Transcript of evidence](#), 5 March 2018, pp 52 – 53; Submission 12, [National Mental Health Commission](#), p 7; Submission 19, [Orygen: the National Centre of Excellence in Youth Mental Health](#), p 8; [Suicide Prevention Collaborative: Illawarra and Shoalhaven](#), p 2; Submission 28, [University of Wollongong: School of Psychology](#), p 9; Submission 32, [YourTown](#), p 19; Ms Skehan, [Transcript of evidence](#), 27 November 2017, p 9

²⁴⁹ Submission 19, [Orygen: the National Centre of Excellence in Youth Mental Health](#), p 8

²⁵⁰ Dr Robinson, [Transcript of evidence](#), 12 February 2018, pp 47 – 48

²⁵¹ Submission 19, [Orygen: the National Centre of Excellence in Youth Mental Health](#), p 2; Submission 21, [Suicide Prevention Collaborative: Illawarra and Shoalhaven](#), p 2

- 4.86 Orygen also drew the Committee's attention to the only established self-harm sentinel data system in Australia, the Hunter Area Toxicology Service (HATS) in Newcastle. The Committee heard that HATS has resulted in shorter hospital stays and overall cost savings.²⁵² Orygen has repeatedly suggested that replicating and expanding this model could greatly improve self-harm data.²⁵³

CASE STUDY: HUNTER AREA TOXICOLOGY SERVICE

The Hunter Area Toxicology Service (HATS) was first established in 1986 and currently operates out of the Calvary Mater Hospital, Newcastle. The purpose of the service is to assess and admit patients who present with self-poisoning. The service also administers a database to record self-poisonings and related patient information such as gender, marital status, length of stay and psychiatric history.

HATS is Australia's only established sentinel data system. Similar poisons databases in England, Scotland, Wales, the USA and Norway have been modelled on the HATS database.

- 4.87 In its 2016 report, *Looking the other way: young people and self-harm*, Orygen recommended expanding HATS to other hospitals to create a multicentre system similar to the one established in the United Kingdom (UK) in 2000. In the UK model, six hospitals collect information on all patients presenting to emergency following an episode of self-harm or suspected self-harm. The selected hospitals draw on patient populations of varying socio-economic and ethnic diversity and in this way are intended to reflect the composition of the national population. Self-harm data from the multicentre system is then used to understand patterns in self-harming and to evaluate treatments.²⁵⁴

- 4.88 Dr Robinson, Orygen, spoke more about the UK model at the hearing:

In England they have sites in Oxford, Manchester and Bristol and they monitor self-harm presentations to all of the key hospitals in those sites. What that allows them to do is build up a strong picture of the epidemiology of self-harm presentations and how they link and relate to suicide rates—so if you are starting to see reductions in suicide attempts, then what you can map that to is changes in suicide rates. We cannot do that here yet, but we are in the process of trying to set something up.²⁵⁵

- 4.89 The Committee also heard that a sentinel system would be shortly trialled in some Sydney hospitals:

²⁵² Dr Robinson, [Transcript of evidence](#), 12 February 2018, p 48

²⁵³ Submission 19, [Orygen: the National Centre of Excellence in Youth Mental Health](#), p 8; Orygen: The Centre of Excellence for Youth Mental Health, 2016, [Looking the other way: young people and self-harm](#), p 7

²⁵⁴ Orygen: The Centre of Excellence for Youth Mental Health, 2016, [Looking the other way: young people and self-harm](#), pp 13 - 14

²⁵⁵ Dr Robinson, [Transcript of evidence](#), 12 February 2018, p 48

As I said, we have obtained a little bit of funding in Victoria to do some work. We have got colleagues here in New South Wales who have got a small pot of money to pilot something here at Westmead hospital and a couple of the other sites around Sydney.

The idea is that we are proceeding as a collaborative and ultimately will be able to link our data and get a really strong picture of what is occurring here in parts of New South Wales compared to what is occurring in Victoria. That is the idea. But the idea of a sentinel system is that you can then do that in real time, so you can track trends as they are occurring. Part of a strong cluster response is monitoring those trends so that you can see if it looks like you have a problem with a suicide cluster emerging.²⁵⁶

Committee comment

- 4.90 Although there is a complex relationship between self-harm and suicide, the Committee acknowledges that there is evidence of a link. While any self-harm is a cause for concern, this link between suicide and self-harm makes the Committee especially troubled by the reported increase in self-harm among children and young people, particularly teenage girls.
- 4.91 At the hearing, the Committee received consistent evidence that data collection on suicide-related behaviours such as self-harm, suicide attempts and suicidal ideation required improvement.
- 4.92 The NSW Government conceded in its submission and in oral evidence that current hospital admissions data for self-harm was not a reliable indicator of self-harm in the New South Wales population.
- 4.93 The Committee understands that the LifeSpan trials involve attempts to improve local data collection arrangements. The Committee also received evidence that a hospital-based linked sentinel system was being trialled at Westmead and other Sydney hospitals.
- 4.94 Nonetheless, the Committee is of the view that the NSW Government should establish a multicentre sentinel system across several hospitals in New South Wales.
- 4.95 A multicentre sentinel system would be a more permanent and systematic way of collecting reliable data on self-harm and suicide attempts. Having accurate and reliable statistics on self-harm in the New South Wales population, particularly children and young people, is crucial to understanding trends and identifying emerging clusters and early intervention strategies.
- 4.96 The Committee suggests that the proposed multicentre sentinel system could be influenced by the model established in the UK, particularly in how it is designed to reflect a representative sample of the population. This hospital-based system should also be informed by the design and experiences of HATS in Newcastle.
- 4.97 To form a more accurate picture of the prevalence of self-harm in the community, the Committee also believes that the ideal model should collect data from emergency departments, hospital admissions and a range of other sources like

²⁵⁶ Dr Robinson, [Transcript of evidence](#), 12 February 2018, p 48

general practitioners, as well as ambulance officers and police who may attend a self-harm incident.

Recommendation 21

The Committee recommends that the NSW Government establish a multicentre sentinel system to collect data on self-harm and suicide attempts.

Chapter Five – Awareness, training and education

- 5.1 This Chapter is about the kinds of conversations our society is having about youth suicide. The Chapter first addresses how we should talk about youth suicide in different contexts. The Committee pays special attention to the role of social media in these conversations.
- 5.2 The Chapter then examines the potential for productive conversations between young people and trusted adults or their peers. In the language of suicide prevention, these people are known as 'gatekeepers'. When done well, conversations with gatekeepers can reduce suicide risk by making young people feel seen and linking them to professional support.
- 5.3 Lastly, the Committee will examine the education and training programs which frame conversations about suicide and mental health in educational settings. The Chapter will focus on programs currently available in New South Wales and will examine potential gaps in the services provided at a primary school and tertiary education level.

Talking about youth suicide

- 5.4 Talking about youth suicide is important. However, it must be done appropriately and sensitively:
- None of us wants to have no conversation about suicide. This is certainly not a topic that should be off the agenda, but we do need to make sure that we handle it as appropriately as possible, and also ensure that our messages are right for the time in which they take place.²⁵⁷
- 5.5 The way we should talk about youth suicide may depend on when and where we talk about it. The evidence shows that talking about suicide the wrong way can increase suicide risk among vulnerable individuals.²⁵⁸ For example, Ms Kristen Douglas of headspace Schools Support said:
- We are very careful to make sure that our messaging is around help-seeking; directing kids, when they are feeling vulnerable and distressed, to mental health services; and not talking about the method and detail of one particular suicide. It is very difficult, because young people are often drawn towards the facts, and they will find connection in that. That is when you see exposure and contagion.²⁵⁹
- 5.6 The Committee also heard about the importance of talking about mental health in children and young people more generally:

²⁵⁷ Ms Skehan, Director, Everymind, [Transcript of evidence](#), 27 November 2017, p 14

²⁵⁸ Ms Skehan, [Transcript of evidence](#), 27 November 2017, p 13, regarding media reporting; Ms Douglas, National Manager, headspace Schools Support, [Transcript of evidence](#), 5 March 2018, p 31, regarding talking about suicide in schools

²⁵⁹ Ms Douglas, [Transcript of evidence](#), 5 March 2018, p 29

For me personally it is about having normalising conversations about mental health specifically in the community and making it not a taboo issue and not be[ing] seen as a parent who is hyper vigilant. It is about normalising these conversations in the community so that families feel confident and okay that it is normal to stand up and say, "I need some support," early rather than late.²⁶⁰

- 5.7 Young people themselves have also suggested that they want a 'more direct approach to talking about suicide and called for programs that could provide them with the skills and resources to respond if they, or someone they know, is struggling or at-risk.'²⁶¹
- 5.8 Conversations about youth suicide and youth mental health occur in many different settings. Being a public health problem, one of the places that conversations about youth suicide occur most frequently is at the government level.
- 5.9 The NSW Government has a special responsibility to talk about suicide in a way which accords with best practice, and in drafting this report the Committee has been mindful of this responsibility.
- 5.10 As a matter of public interest, youth suicide is also a topic which is regularly reported on in the media. Given its reach and influence, it is important that the media strives to talk about suicide in accordance with best practice resources, such as those produced by Mindframe.²⁶² For example, Mindframe advises that the media should minimise details about method and location of death, ensure accuracy and context (for instance, by not attributing a death to a single cause), and use appropriate language which does not stigmatise or sensationalise suicide.²⁶³
- 5.11 Conversations about suicide also take place in local communities. Unfortunately, while these conversations are often triggered by a death in the community, the Committee heard that communities also need to be careful in how they talk about suicide in the immediate period following a death.²⁶⁴ *Conversations Matter* is an example of a free online resource which assists communities to have sensitive conversations about suicide.²⁶⁵
- 5.12 Importantly, conversations about mental health sometimes occur most naturally in the context of interpersonal relationships, including within families, between friends or with a teacher. For this reason, part of this Chapter will focus on the evidence received on training these 'gatekeepers' to know when and how to have conversations about mental health with young people.

²⁶⁰ Mr Heard, Clinical Leader, Aboriginal Psychologist, Wiyiliin Ta, Hunter Child and Adolescent Mental Health Service, [Transcript of evidence](#), 27 November 2017, p 25

²⁶¹ Submission 19, [Orygen](#), p 10

²⁶² Ms Skehan, [Transcript of evidence](#), 27 November 2017, p 11

²⁶³ Mindframe, [Reporting suicide: a quick guide for the media](#)

²⁶⁴ Ms Skehan, [Transcript of evidence](#), 27 November 2017, p 14; Mr Bryant, Program Manager, Suicide, Everymind, [Transcript of evidence](#), 27 November 2017, p 13

²⁶⁵ Ms Skehan, [Transcript of evidence](#), 27 November 2017, p 14

Committee comment

- 5.13 It is important that our society talks about suicide and suicide-related behaviours like self-harm. Talking about suicide is the first step to acknowledging that there is a problem, so we can then work towards possible solutions.
- 5.14 While we should talk about suicide, the Committee acknowledges that we need to be careful how we talk about it. This is because the evidence suggests that talking about suicide the wrong way may increase suicide risk. How we should talk about suicide may be influenced by when, where and with whom we are talking.
- 5.15 Throughout this inquiry, the Committee has seen that communities play an important role in suicide prevention. The systems-based approach to suicide on which LifeSpan is based recognises that each community is unique and usually well-placed to identify problems as well as potential solutions. For this reason, the conversations taking place about suicide within communities are of particular significance.
- 5.16 The Committee has heard many stories about communities who have been working together to promote good mental health among their children and young people and prevent further youth suicides. In particular, the Committee commends the Upper Hunter, Clarence Valley and Lithgow for their willingness to have these difficult conversations about youth suicide and youth mental health generally.
- 5.17 The Committee also acknowledges the importance of conversations children and young people may have with trusted adults, including their parents, as well as their peers. Because these conversations play a special role in helping to identify children and young people in distress, the Committee will pay special attention to the role of these 'gatekeepers' later in this Chapter.

Role of social media

- 5.18 Social media is an arena where conversations relating to mental health increasingly take place. The Committee will address the role of social media separately because it was understandably an issue which was raised during the course of the inquiry. Young people are generally well-versed in the use of social media and, overall, the Committee heard that social media plays a special but complicated role in youth suicide and suicide-related behaviours.
- 5.19 The Committee heard that the way social media can connect young people changes the way we should think about the communities young people can be a part of:

People who are distantly connected to a young person can also be seriously impacted by a death. Social media, the ways in which young people communicate and the connections they make as communities are no longer just geographic. We really need to be thinking about how we operate in the communities in which young people interact, which are not always geographic.²⁶⁶

²⁶⁶ Ms Skehan, [Transcript of evidence](#), 27 November 2017, p 12

5.20 While social media can sometimes portray suicide and related behaviours in a way which is unhelpful and increases stigma,²⁶⁷ the Committee also heard that social media was a place where productive conversations about these issues could occur:

Interestingly, when we did our research with young people and asked them about online experiences hardly anyone chose to write about being bullied online or having poor online experiences. In fact, they hardly chose to write about online experiences at all, which I cannot explain. On the odd occasion that they did, they talked about finding a place on social media where they found other young people who they could connect with, who understood them and had gone through similar experiences. There are two sides to social media and maybe we lose sight of the fact that there are potential positive benefits as well.²⁶⁸

5.21 The use of social media may also provide insight into those young people that may be at risk of suicide or self-harm.²⁶⁹ Others supported the view that social media could also be a platform for promoting mental wellbeing and destigmatising mental ill health.²⁷⁰ At the hearing, headspace provided an example of how it used Facebook to encourage help seeking among young people at a time of particular vulnerability.²⁷¹

CASE STUDY: HARNESSING THE POWER OF FACEBOOK IN GRAFTON

headspace School Support worked with Facebook during a time of heightened suicide risk for young people in the Grafton community. Geotargeted mapping was used to deliver Facebook advertisements about mental health services to students while they were on school holidays and otherwise difficult to reach. Over 48 hours, these targeted advertisements were viewed by 10,000 people.

Ms Douglas, *Transcript of evidence*, 5 March 2018, p 27

5.22 There was also considerable discussion between the Committee and witnesses about the link between bullying on the internet, particularly social media, and the risk of youth suicide. While media reports may often portray cyber bullying as the cause of a young person's suicide, witnesses suggested that there was no established link between bullying on social media and youth suicide as yet. It is one

²⁶⁷ Mr Woodward, Executive Director, Lifeline, [Transcript of evidence](#), 5 March 2018, p 9; see also Ms Douglas, [Transcript of evidence](#), 5 March 2018, p 27 about the risks of social media

²⁶⁸ Ms Batchelor, Senior Researcher, yourtown (Kids Helpline), [Transcript of evidence](#), 5 March 2018, p 9; see also Dr Wright, NSW Chief Psychiatrist, Ministry of Health, [Transcript of evidence](#), 5 March 2018, p 54 and Mr Bryant, [Transcript of evidence](#), 27 November 2017, p 12

²⁶⁹ Dr Shand, Senior Research Fellow and Research Director, Lifespan, Black Dog Institute, [Transcript of evidence](#), 5 March 2018, p 11; Dr O'Dea, Research Fellow, Black Dog Institute, [Transcript of evidence](#), 5 March 2018, p 12; Mr Bryant, [Transcript of evidence](#), 27 November 2017, p 12

²⁷⁰ Dr Shand, [Transcript of evidence](#), 5 March 2018, p 11; Ms Douglas, [Transcript of evidence](#), 5 March 2018, p 27; Ms Bale, Relieving executive Director, Learning and Wellbeing, NSW Department of Education, [Transcript of evidence](#), 5 March 2018, p 48

²⁷¹ Ms Douglas, [Transcript of evidence](#), 5 March 2018, p 27

of a number of factors to consider in a complex area.²⁷² Dr Bridianne O'Dea, Research Fellow at the Black Dog Institute, commented:

When a youth suicide occurs—as you would all know we have had quite a few high profile suicides in New South Wales in the last few years—we have seen the media immediately report that social media bullying was a big part in the suicide. Unfortunately, that does a lot of damage because it takes away from the fact that suicide is very complex and that we do not really have a definitive causation link between bullying on social media and suicide prevention. In fact, all of the evidence that exists for a link between social media and mental health actually is quite weak. In my own research in my PhD I looked at the effect of social media on young people's emotional wellbeing and actually found the same results that the former speakers were saying, in that it is actually your family support that is the overarching dominant factor in young people's mental health.²⁷³

5.23 However, the Committee also heard that there may not be much evidence on the effects of social media, given that it has developed at a speed greater than traditional research.²⁷⁴

5.24 In their submission, Beyond Blue stated that social media is still a relatively new phenomenon and researchers are still assessing its positive and negative impacts:

While researchers continue to grapple with the potential positive and negative impacts of websites and social media for suicide prevention, it must be acknowledged that this is still an emerging area of understanding.²⁷⁵

5.25 Beyond Blue further submitted that research on cyberbullying is scant however acknowledged that children who have been victims of bullying show signs of depression and have an increased risk of contemplating or attempting suicide.

5.26 Beyond Blue recommends more research in this area focusing on children and young people given their high use of social media:

More research is needed to understand the extent of social media's positive and negative influences on suicidal behaviour and the extent to which people's privacy can be respected while providing avenues to reach out to people at risk, as well as how we can protect people's freedom of speech while counteracting harmful content that may place people at risk. Research should take a focussed approach for young people and adolescents in particular, as a high user group of social media.²⁷⁶

Committee comment

5.27 The Committee recognises that social media has an increasing role to play in suicide prevention, particularly among children and young people. As mentioned by many inquiry participants, the Committee accepts that this may be both positive and negative.

²⁷² For example, see Dr O'Dea, [Transcript of evidence](#), 5 March 2018, p 12; Mr Trethowan, Chief Executive Officer, headspace, [Transcript of evidence](#), 5 March 2018, p 28;

²⁷³ Dr O'Dea, [Transcript of evidence](#), 5 March 2018, p 12

²⁷⁴ Ms Skehan, [Transcript of evidence](#), 27 November 2017, p 12

²⁷⁵ Submission 51, [Beyond Blue](#), p 15

²⁷⁶ Submission 51, [Beyond Blue](#), p 16

- 5.28 While the role of social media in youth mental health may be complicated, the Committee acknowledges that social media may be a powerful tool to drive help-seeking and anti-stigma messages to children and young people at risk of suicide.
- 5.29 The Committee acknowledges the lack of evidence that there is a link between bullying on social media and suicide risk in young people. However, the Committee notes that it is one risk factor to consider in a complex, multi-issue area and should be addressed through systematic, evidence based measures to reduce bullying and its harms.
- 5.30 Given that it is still an emerging area, the Committee considers that it is important to conduct further research into the impact of social media on youth suicide.

Recommendation 22

The Committee recommends that the NSW Government support research into the impact of social media on youth suicide.

Gatekeeper training

- 5.31 Gatekeepers are people who come into contact with at-risk individuals who may be in a position to influence that individual's decision to access help.²⁷⁷ While gatekeepers can be varied, they are all in a position to make children and young people feel valued and heard. They can include friends, parents, the local GP or teachers:

Encouragingly, young people also told us that when they did receive help, it usually made a difference ... What was also clear was that the value of genuine caring and compassion is not limited to a therapeutic relationship. Whether they are talking to a GP, a teacher at school, a parent, a friend or a nurse in an emergency department, young people are seeking evidence that they are valued and important.²⁷⁸

- 5.32 Many witnesses also spoke to the special relationship between a child or young person at risk and a parent. For example:

Having a loving parental relationship or care-giving relationship certainly is a really important protective factor for children.²⁷⁹

...

In my own research in my PhD I ... actually found the same results that the former speakers were saying, in that it is actually your family support that is the overarching dominant factor in young people's mental health.²⁸⁰

...

²⁷⁷ LifeSpan Integrated Suicide Prevention and the Black Dog Institute, [LifeSpan Integrated Suicide Prevention: Summary Paper](#), July 2016, p 5

²⁷⁸ Ms Batchelor, [Transcript of evidence](#), 5 March 2018, p 3

²⁷⁹ Ms Swinfield, Director Practice Support, Office of the Senior Practitioner, NSW Department of Family and Community services, [Transcript of evidence](#), 5 March 2018, p 39

²⁸⁰ Dr O'Dea, [Transcript of evidence](#), 5 March 2018, p 12

Moreover, in addition to being a crucial source of support, in and of themselves, parents are the gateway to professional support for children.²⁸¹

- 5.33 That said, it is sometimes difficult for parents to know how to respond in the right way to a child who may be in distress.²⁸² Also, some of the children at highest risk may be unlikely to trust the adults around them, or their school.²⁸³ Other children, such as those identifying or beginning to identify as LGBTI, may also prefer to reach out to their LGBTI peers.²⁸⁴ Some children also have families that may not be supportive.²⁸⁵
- 5.34 There was also evidence that it is important that gatekeeper is defined broadly, because young people are likely to come into contact with many different types of people.²⁸⁶ It was suggested that school counsellors, juvenile justice and child protection workers may all be gatekeepers.²⁸⁷
- 5.35 When children and young people first reach out, it is critical that the gatekeeper they speak with responds appropriately and sensitively:
- I think the important point is really understanding that the first contact becomes critical – whether that contact is a parent, a teacher, the general practitioner, a peer – and ensuring that, as a community, we know how to respond. If that initial response is not one of being able to support and is not a positive experience, that will shut down help seeking into the future.²⁸⁸
- 5.36 The Committee heard that gatekeeper training is generally recognised both internationally and domestically as a key strategy in suicide prevention.²⁸⁹ Indeed, training gatekeepers is one of nine 'evidence-based strategies' which will be implemented as part of the LifeSpan trials in New South Wales and wider Australia.²⁹⁰ A key part of this strategy is the delivery of Question, Persuade, Refer (QPR), a short online training module.
- 5.37 The Committee also heard evidence that training equips gatekeepers to connect with young people in an informed way:

²⁸¹ Ms Batchelor, [Transcript of evidence](#), 5 March 2018, p 3

²⁸² Commissioner Lourey, Commissioner, Mental Health Commission of New South Wales, [Transcript of evidence](#), 12 February 2018, p 29

²⁸³ Dr O'Dea, [Transcript of evidence](#), 5 March 2018, p 12

²⁸⁴ Ms Lambert, Director, Community Health and Regional Services, Aids Council of New South Wales, [Transcript of evidence](#), 5 March 2018, p 21

²⁸⁵ Mr Humphreys, Co-executive Director, Twenty10, [Transcript of evidence](#), 5 March 2018, p 21; Ms Kotselas, [Transcript of evidence](#), 5 March 2018, p 45

²⁸⁶ Mr Woodward, [Transcript of evidence](#), 5 March 2018, p 8; Mrs Brogden, Co-Chair, National Mental Health Commission, [Transcript of evidence](#), 12 February 2018, p 30

²⁸⁷ Mr Woodward, [Transcript of evidence](#), 5 March 2018, pp 8 – 9; Mr Humphreys, [Transcript of evidence](#), 5 March 2018, p 21

²⁸⁸ Ms Adams, Chief Executive Officer, yourtown (Kids Helpline), [Transcript of evidence](#), 5 March 2018, p 8

²⁸⁹ Mr Woodward, [Transcript of evidence](#), 5 March 2018, p 8; see also Black Dog Institute, [Training the community to recognise and respond to suicidality](#), p 1, which indicates that the United Nations and World Health Organisation have endorsed gatekeeper training. See also Mr Johnson, Advocate for Children and Young People, [Transcript of evidence](#), 12 February 2018, p 38

²⁹⁰ LifeSpan Integrated Suicide Prevention and the Black Dog Institute, [LifeSpan Integrated Suicide Prevention: Summary Paper](#), July 2016, p 4

The gatekeeper training is about having the ability to ask two or three questions you need to of a young person when you notice they are in distress or at risk. Those two or three questions include: Have you had thoughts of hurting yourself or killing yourself? If so, do you have a method or a plan? Do you have a timeline to your plan? Those are three very difficult questions to ask a young person.²⁹¹

- 5.38 To this end, the Department of Education gave evidence that it is investigating making the LifeSpan-endorsed QPR module available to all school staff and beyond to the school community.²⁹²
- 5.39 While the evidence demonstrates that gatekeeper training such as QPR increases awareness of suicide risk factors and improves prevention skills, the Committee heard evidence that as yet there is no direct evidence that such training decreases suicidal behaviour.²⁹³

Gatekeeper training and FACS

- 5.40 When questioned about the role of child protection workers as gatekeepers, Ms Pam Swinfield, a representative from the Department of Family and Community Services (FACS) said:

I think we certainly are already in that space to some extent. However, I think that there are such pressures on our system because of the range of issues that people present with and certainly the gamut of vulnerabilities that children – very young babies through to older teenagers – present with that it is always going to be impossible to ensure that we are able to meet the needs that the demand presents.

...While I think it is appropriate that we are a point that could perhaps identify the risk – and we do that currently – there are challenges in a stretched system being overloaded by that responsibility.²⁹⁴

- 5.41 In response to a question on notice, FACS confirmed that the Caseworker Development Program which is compulsory for new child protection workers did not include any content on young people and suicide. While there is an internal practice kit on mental health issues which is available to FACS workers, the FACS response noted that the Caseworker Development Program was currently under revision and suggested that there would be an opportunity to introduce all new staff to this mental health practice kit.²⁹⁵
- 5.42 The Committee considered the current approach to suicide prevention for those with a child protection history in further detail in Chapter 2.

Committee comment

- 5.43 The Committee received considerable evidence about the importance of gatekeepers in suicide prevention. Children and young people engage with a

²⁹¹ Ms Douglas, [Transcript of evidence](#), 5 March 2018, p 29

²⁹² Ms Bale, Relieving Executive Director, NSW Department of Education, [Transcript of evidence](#), 5 March 2018, p 42; Ms Kotselas, [Transcript of evidence](#), 5 March 2018, p 48

²⁹³ Black Dog Institute, [Training the community to recognise and respond to suicidality](#), p 1; see also Orygen: National Centre of Excellence in Youth Mental Health, [Raising the bar for youth suicide prevention](#), 2016, p 40

²⁹⁴ Ms Swinfield, [Transcript of evidence](#), 5 March 2018, p 35

²⁹⁵ Department of Family and Community Services, [Answers to questions taken on notice](#), 23 April 2018, p 1

variety of people, including parents, friends, teachers, GPs, and sports coaches, and so gatekeepers take many forms. Ensuring these people are appropriately trained to respond sensitively to the needs of children and young people is very important, as children may be less likely to reach out if their first encounter with a gatekeeper is a negative one.

- 5.44 Gatekeeper training is one of the strategies being delivered as part of the LifeSpan trial sites. However, given the considerable favourable evidence the Committee received in relation to the value of gatekeepers, the Committee recommends that the NSW Government investigate expanding gatekeeper training beyond the LifeSpan trial sites to persons across the State that may regularly come into contact with children and young people.
- 5.45 While the Committee acknowledges that there is no direct evidence that gatekeeper training prevents suicide deaths, the balance of the evidence received during this inquiry suggests that gatekeeper training is a valuable tool in suicide prevention. Given that gatekeeper training is a cornerstone of the LifeSpan trial, the NSW Government is likely to be influenced by LifeSpan's evaluation research in any decision to expand gatekeeper training further across the State.
- 5.46 The Committee commends the Department of Education for its proactive approach to gatekeeper training through investigating the potential for the LifeSpan-endorsed QPR to be made available to all school staff and to the broader school community.
- 5.47 This inquiry has heard that children and young people with a child protection history are at particular risk of suicide. While FACS acknowledged that, to an extent, its child protection workers are already gatekeepers, it was suggested that the pressures on the system may impede the ability of such workers to perform their gatekeeper function effectively. Again, the Committee understands that there is no content on youth suicide which forms part of the compulsory Caseworker Development Program for all new child protection workers.
- 5.48 Although we acknowledge that responding to the competing needs of many vulnerable children is a difficult task, the Committee is concerned that child protection workers may not be appropriately trained to identify and respond to children and young people at risk of suicide. This is especially the case given that those with a child protection history are at increased risk of suicide.
- 5.49 For this reason, the Committee recommends that the NSW Government make training on youth suicide prevention, including gatekeeper training, compulsory for all child protection workers and fosters carers.

Recommendation 23

The Committee recommends that the NSW Government expand gatekeeper training beyond the LifeSpan trial sites targeting persons across New South Wales who are likely to come into regular contact with children and young people.

Recommendation 24

The Committee recommends that the NSW Government make training on youth suicide prevention, including gatekeeper training, compulsory for all child protection workers and foster carers.

Mental health education in schools for students and staff

5.50 Schools provide a unique opportunity to engage with a large number of children and young people about issues relating to mental health and wellbeing:

I think that it is important that the Department of Education and other education providers are major partners when we are thinking about young people. We have a unique opportunity to capture young people from usually the age of three right through until at least 18 in educational environments in NSW.²⁹⁶

5.51 During this inquiry, the Department of Education gave extensive evidence about its ongoing efforts to foster student wellbeing, emphasising its evidence-based approach.²⁹⁷ It has implemented several education and training initiatives in New South Wales government schools which promote mental health and wellbeing among its students and also some which train staff in youth suicide prevention.²⁹⁸

5.52 A snapshot of the education and training initiatives available in NSW Government schools appears below.

Table 2: Snapshot of education and training initiatives in New South Wales government schools

INITIATIVE	DESCRIPTION
PDHPE	Mandatory for K - 10. Contains mental health content. Syllabus under review.
CROSSROADS	Mandatory mental health program for senior students in Government schools
SUPPORTED STUDENTS, SUCCESSFUL STUDENTS	Wellbeing package for 236 school counselling positions, 200 Student Support officers, and support for whole-school approaches to positive behaviour
SCHOOL-LINK	Partnership with Ministry of Health which provides evidence-based early intervention programs and access to CAMHS for higher risk students
GETTING ON TRACK IN TIME	Early intervention program for students in K-2 with emerging conduct disorders
PROJECT AIR FOR SCHOOLS	Training for high school teachers regarding significant mental health issues.
YOUTH AWARE OF MENTAL HEALTH (YAM)	Evidence-based suicide prevention program for 14 – 16 year olds. 10 more YAM trainers have been funded. LifeSpan evaluations may inform further expansion.

²⁹⁶ Ms Skehan, [Transcript of evidence](#), 27 November 2017, p 17

²⁹⁷ Ms Kotselas, [Transcript of evidence](#), 5 March 2018, p 47

²⁹⁸ See Submission 46, [NSW Government](#), pp 26 – 28, 34 – 37

QUESTION, PERSUADE, REFER (QPR)	Online gatekeeper training for school staff. Part of LifeSpan trial but Department working with BlackDog to expand across New South Wales
ADVANCED TRAINING IN SUICIDE PREVENTION	Training for school counsellors to assist them in identifying students at suicide risk. Working with Black Dog to customise existing module
RESPONDING TO STUDENT SUICIDE SUPPORT GUIDELINES FOR SCHOOLS	Developed in 2015 with headspace School Support and Ministry of Health
VARIOUS TRAINING COURSES	For school leaders, teachers and/or school counsellors, e.g.: Exploring Strategies to Prevent and Respond to Youth Suicide; Youth Mental Health First Aid; Teaching Students who have Experienced Trauma; Professional Certificate in Education (Positive Education); Graduate Certificate in Development Trauma
THEIR FUTURES MATTER	From March 2018, school counsellors work with FACS psychologists providing trauma-informed training to public schools about students in out-of-home-care

5.53 While the Committee received a submission from the Association of Independent Schools NSW (AISNSW),²⁹⁹ overall the Committee received limited evidence on the suicide prevention programs and activities available in non-government schools.

5.54 However, the Committee understands that although independent schools may vary in their approaches to suicide prevention depending on the philosophy of the school, they generally have access to some of the resources and programs that are available in New South Wales Government schools, such as KidsMatter and MindMatters.³⁰⁰ AISNSW also partners with headspace School Support in providing support after a suicide, including ongoing wellbeing initiatives.³⁰¹ The provision of support for the community after a suicide, in order to prevent further suicides, is known as 'postvention.'

5.55 Relevantly, until at least Year 10, all students in New South Wales study Personal Development, Health and Physical Education (PDHPE), which contains content on mental health and wellbeing.³⁰²

5.56 Ms Douglas of headspace School Support spoke positively about the work undertaken by the Department of Education, as well as Catholic and independent schools, in the field of suicide prevention:

Headspace has worked with the education systems and sectors across every State and Territory and has a particularly healthy and positive relationship with the New South Wales Department of Education, and the Catholic and independent sectors. They have done some commendable work in policy development, program development and

²⁹⁹ Submission 38, [Association of Independent Schools NSW](#)

³⁰⁰ Submission 38, [Association of Independent Schools NSW](#), p 7

³⁰¹ Submission 38, [Association of Independent Schools NSW](#), pp 7 - 8

³⁰² Submission 38, [Association of Independent Schools NSW](#), p 2

workforce capability and capacity building. We continue to work with them in the field across New South Wales schools.³⁰³

5.57 Ms Douglas further stated:

Policy-wise and structurally wise, New South Wales has a very comprehensive platform of services ... I would say that the mental health literacy and help-seeking approaches by the Department of Education has been a huge contributing factor. There are a lot of things going right in New South Wales, and we now apply that knowledge to other States and Territories.³⁰⁴

5.58 However, the Committee also received evidence to suggest that suicide prevention activities in schools were at times uncoordinated and lacked consistency. For example, Youth Action suggested that because each school could decide where to deploy their wellbeing budget, this led to inconsistent services. It also noted that the Department of Education no longer provided centralised support and training of Student Support officers as part of the *Supported Students, Successful Students* program, which in its view resulted in 'isolation, high stress and turnover'. For these reasons, Youth Action suggested that current support for suicide prevention in schools is 'ad-hoc and under-effective'.³⁰⁵

5.59 The Centre for Emotional Health at Macquarie University also suggested that in their experience school counsellors sometimes did not use evidence-based interventions when treating children with anxiety.³⁰⁶

5.60 In addition, Orygen expressed concerns that in response to some youth suicides, programs or information sessions have been delivered in schools by individuals who, although well-intentioned, may not be appropriately trained and may lack awareness of evidence-based postvention. This may increase the risk of harm to other students in the wake of a suicide death and for this reason a consistent and evidence-based postvention approach in schools should be advocated.³⁰⁷

5.61 Two areas where the Committee received evidence of gaps in the provision of youth suicide prevention services in educational settings was at the tertiary and primary school levels.³⁰⁸

³⁰³ Ms Douglas, [Transcript of evidence](#), 5 March 2018, p 26; see also Ms Skehan, [Transcript of evidence](#), 27 November 2017, p 18 and Mrs Carrigan, Founder, Where's There's a Will (Upper Hunter), [Transcript of evidence](#), 27 November 2017, p 36

³⁰⁴ Ms Douglas, [Transcript of evidence](#), 5 March 2018, p 29

³⁰⁵ Submission 52, [Youth Action](#), p 22

³⁰⁶ Submission 24, [Macquarie University, Centre for Emotional Health](#), p 4

³⁰⁷ Submission 19, [Orygen](#), p 10

³⁰⁸ Mr Trethowan, Chief Executive Officer, headspace, [Transcript of evidence](#), 5 March 2018, pp 29 – 30; Ms Douglas, [Transcript of evidence](#), 5 March 2018, p 29; Ms Skehan, [Transcript of evidence](#), 27 November 2017, p 18; Ms Batchelor, [Transcript of evidence](#), 5 March 2018, p 4; Ms Skehan, [Transcript of evidence](#), 27 November 2017, pp 11, 17; Submission 28, [University of Wollongong, School of Psychology](#), pp 9 – 10; Ms Douglas, [Transcript of evidence](#), 5 March 2018, p 31

- 5.62 With regard to TAFEs and universities, the Committee heard that young people undergoing transition, including from high school to tertiary education, may be especially vulnerable to suicide and self-harm.³⁰⁹ Mr Trethowan said:

I think where we would see the next priority beyond the school system is actually in university and TAFEs. We ... released a report in early 2017 which highlighted that 35.4 per cent of respondents had thoughts of self-harm or suicide, which is significantly higher than, obviously, other parts of the population. Transitions in life—whether it be from primary school to secondary school or, in the case of suicide, more so from secondary school to tertiary studies or to the real world when you have to go out and get your first job or move out of home—a whole range of factors are obviously leading young people to question around their mental health and wellbeing. We know that through research that others, like Orygen, have done in Australia and we know from engagement with the universities and the institutions themselves around the risk of suicide and self-harm, and it is something at the moment that we are not doing well enough. ... there is a big gap in our university and TAFE sector.³¹⁰

- 5.63 Ms Skehan also highlighted the gap in services provided to the TAFE and university sector and advocated a coordinated approach:

One thing the Committee should consider—...— is we do not actually have a coordinated national-State approach to TAFE and university. If you look at where we get high numbers of suicide deaths occurring, just in an age group population, we are often talking about young people who have just left school and who may be in touch with either further training or out of employment. I would say that is one of our current gaps.³¹¹

- 5.64 Two submissions also supported the view that TAFE and university was a current gap.³¹² In particular, in their joint submission Orygen, Lifeline and batyr recommended that the NSW Government 'extend the delivery of any education-based mental health and suicide prevention programs/activities (including postvention programs) into tertiary education settings.'³¹³

- 5.65 With regard to primary schools, Ms Douglas of headspace School Support suggested that suicidal risk among younger children was increasing, because of increasing levels of distress generally and exposure to online information about how to self-harm.³¹⁴

- 5.66 Orygen explained that the different approach to suicide prevention in primary schools may be because of historical concerns about the safety of such educational programs:

Historically, education about suicide or suicide-related behaviours has not been a feature of many government funded mental health education programs due to

³⁰⁹ Mr Trethowan, [Transcript of evidence](#), 5 March 2018, p 29

³¹⁰ Mr Trethowan, [Transcript of evidence](#), 5 March 2018, pp 29 - 30

³¹¹ Ms Skehan, [Transcript of evidence](#), 27 November 2017, p 18

³¹² Submission 19, [Orygen: the National Centre of Excellence in Youth Mental Health](#), pp 2, 7, 8 and 11; Submission 34, [Lifeline Australia, Orygen and batyr](#), p 9

³¹³ Submission 19, [Orygen: the National Centre of Excellence in Youth Mental Health](#), pp 2, 7, 8 and 11; Submission 34, [Lifeline Australia, Orygen and batyr](#), p 9

³¹⁴ Ms Douglas, [Transcript of evidence](#), 5 March 2018, p 31

concerns about the efficacy and safety of suicide specific school programs. This is particularly the case in primary schools, even though there have been an increasing number of suicides reported among young people under the age of 14 years, and postvention responses may be required in these settings.³¹⁵

- 5.67 In its 2016 report on youth suicide, Orygen also suggested that there is a lack of postvention services in both primary schools and tertiary education settings.³¹⁶
- 5.68 Examples of current education programs capturing primary school children include the general PDHPE curriculum, and also *Getting on Track in Time (Got It)* for children with emerging conduct disorders. However, aside from the *Good Behaviour Game* recommended by Black Dog,³¹⁷ the Committee received limited evidence about what new prevention activities were suitable for primary school children.

Filling school counsellor positions

- 5.69 At its first hearing in Singleton, the Committee heard that despite funding for six counsellor positions in upper Hunter schools, only 3.2 of these positions were filled.³¹⁸

... There were 3.2 counsellors at the time because they do not exist and they will not come here. The funding was put up for six and they were trying hard to get six, but they could get only 3.2. It is not that anyone is lying; the funding is available, but you will not get psychologists and counsellors to come to regional areas when they can live at Newcastle Beach.³¹⁹

- 5.70 At the same hearing, representatives from the Department of Education were asked about these unfilled positions. Ms Sue Macindoe, Leader – Psychology Practice at the Department of Education, confirmed that despite 236 new school counsellor positions being funded across the State in 2016, new pathways were needed to fill some of these positions:

...I do not know how many school counselling positions are in this area locally. What I can tell you is that there has been an increase in the number of school counsellor positions, with 236 new positions rolled out last year. We have not been able to fill all of those positions at the current time, but we are looking at new pathways to fill the positions and new training opportunities – new university pathways into school counselling positions as well as sponsorships or retraining.³²⁰

- 5.71 The Committee understands that the 236 new school counselling positions were part of the *Supported Students Successful Students* package.³²¹

³¹⁵ Submission 19, [Orygen](#), p 10

³¹⁶ Orygen: National Centre of Excellence in Youth Mental Health, [Raising the bar for youth suicide prevention](#), 2016, p 42

³¹⁷ Dr Shand, [Transcript of evidence](#), 5 March 2018, p 11

³¹⁸ Mrs Carrigan, [Transcript of evidence](#), 27 November 2018, p 31

³¹⁹ Mrs Carrigan, [Transcript of evidence](#), 27 November 2018, p 31; see also Ms Scott, Service Manager, headspace Newcastle, [Transcript of evidence](#), 27 November 2017, p 32

³²⁰ Ms Macindoe, Leader-Psychology Practice, NSW Department of Education, [Transcript of evidence](#), 27 November 2017, p 36

³²¹ Submission 46, [NSW Government](#), p 40

- 5.72 Many other inquiry participants also expressed concerns at a lack of counsellors in schools.³²²

Committee comment

- 5.73 Overall, the Committee was impressed with the quality of evidence provided by the Department of Education and are of the view that the Department generally takes student wellbeing and youth suicide prevention in schools seriously. This was a view which appeared to be shared by other inquiry participants.
- 5.74 Unfortunately, the Committee received less evidence about the suicide prevention activities in non-government schools and for this reason it is difficult to comment on the adequacy of services provided in such schools.
- 5.75 While schools generally appear to treat student wellbeing seriously, the Committee notes that there was some evidence to suggest that suicide prevention activities in schools lacked coordination and consistency.
- 5.76 The Committee recognises the valuable contribution that school counsellors, nurses, chaplains and special religious education plays in providing assistance and support to children. They have an important role in providing children an opening or opportunity to have conversations about their wellbeing.
- 5.77 The Committee has identified two main gaps in the provision of suicide prevention activities in educational settings. The most significant gap appears to be in tertiary education, rather than schools. The transition to life after high school seems to be a time of heightened vulnerability for young people, which makes it even more important that appropriately-gearred education and training in suicide prevention, including postvention, is provided at the tertiary level.
- 5.78 To address the gap in higher education, the Committee recommends that the NSW Government work with the tertiary education sector to implement suicide prevention activities in universities and TAFEs in New South Wales.
- 5.79 The second opportunity for improvement is in the education and training provided in primary schools. During this inquiry the Committee was troubled by stories and thoughts of suicide occurring in children as young as 7 and 8. Although suicide in these younger age groups is less prevalent, the Committee heard evidence to suggest that this was an area of increasing concern and that there should be more prevention programs targeted at primary school children. This would help address emergent risk in children at an earlier stage.
- 5.80 While the terms of reference for this inquiry focused on young people aged 12 and under 25, the Committee has been persuaded that the NSW Government should review its approach to suicide prevention in primary schools in New South Wales.
- 5.81 Specifically, the Committee recommends that the NSW Government commission a review into the adequacy and efficacy of the suicide prevention, postvention and

³²² Submission 15, [Upper Hunter Where There's a Will](#), p 3; Submission 23, [Federation of Parents and Citizens Association of New South Wales](#), p 3; Submission 52, [Youth Action](#), p 22; see also Submission 14, [Catholic Women's League](#), p 6. That submission emphasised the importance of school counsellors and suggested that there should be a 'minimum standard for the presence of counsellors in all schools.'

mental health and wellbeing activities currently provided to primary school students in New South Wales.

5.82 The Committee acknowledges that the NSW Government has invested funds to create new school counsellor positions across the State. Despite an increase in the number of funded school counsellor positions, the Committee heard that some of these positions, particularly in rural and regional areas, have proved difficult to fill. The Department of Education advised that it was investigating new pathways to fill these positions.

5.83 The Committee recommends that the NSW Government prioritise filling these school counsellor positions, particularly in regional, rural and remote areas.

Recommendation 25

The Committee recommends that the NSW Government work with the tertiary education sector to implement suicide prevention activities, including postvention, in universities and TAFEs in New South Wales.

Recommendation 26

The Committee recommends that the NSW Government reviews the adequacy and efficacy of the suicide prevention, postvention and mental health and wellbeing programs currently provided to primary school students in New South Wales.

Recommendation 27

The Committee recommends that the NSW Government prioritise filling school counsellor positions, particularly in regional, rural and remote areas.

Appendix One – Terms of reference

That the Committee on Children and Young People inquire into and report on the current approaches aimed at preventing youth suicide in New South Wales, with particular reference to:

- a. Any gaps in the coordination and integration of suicide prevention activities and programs across all levels of government
- b. Governance arrangements and accountabilities for suicide prevention
- c. Provision of services in local communities, particularly in regional and rural areas
- d. Provision of services for vulnerable and at-risk groups
- e. Data collection about the incidence of youth suicide and attempted suicide
- f. Provision of high-quality information and training to service providers
- g. Approaches taken by primary and secondary schools
- h. Any other related matters.

The Committee is adopting the definition of ‘young person’ outlined in the *Advocate for Children and Young People Act 2014*, which is a person who is 12 years of age or above but under 25 years of age.

Appendix Two – Conduct of inquiry

Terms of reference

On 22 June 2017, the Committee resolved to conduct an inquiry into the prevention of youth suicide in New South Wales and adopted the inquiry's terms of reference (Appendix One).

Submissions

The Committee called for submissions by issuing a media release and writing to key stakeholders inviting them to make a submission. Submissions closed on 31 August 2017.

The inquiry received 57 submissions from a wide range of stakeholders including members of the public, suicide prevention service providers, mental health carers, community groups, suicide prevention researchers and government agencies. A list of submissions is available at Appendix Three.

Hearings

On 27 November 2017, the Committee conducted a public hearing in Singleton. On the same day the Committee also conducted a private round-table session with people with lived experience of suicide.

The Committee conducted three public hearings at Parliament House. On 12 February 2018 the Committee heard from the NSW Coroner, the Australian Bureau of Statistics, government agencies and academic researchers. On 5 March 2018 the Committee heard from advocacy groups, suicide prevention service providers and government representatives. On 30 April 2018 the Committee heard evidence from Professor Pat Dudgeon from the School of Indigenous Studies, University of Western Australia.

A list of witnesses is available at Appendix Four.

The Committee thanks all inquiry participants for their contribution to the inquiry.

Appendix Three – Submissions

1	Miss Elizabeth Veasey
2	Mr Chris Hamill
3	Benchmark Analytics
4	Mr Paul Robertson
5	Suicide Program
6	Lithgow City Council
7	Mr Alastair Lawrie
8	Aboriginal Child, Family and Community Care State Secretariat
9	Mind Blank
10	University of New England
11	NSW Mental Health Commission
12	National Mental Health Commission
13	Grand Pacific Health
14	Catholic Women's League NSW
15	Where There's A Will (Upper Hunter)
16	The Jack Luck Foundation
17	Confidential
18	Clarence Valley Council
19	Orygen, The National Centre of Excellence in Youth Mental Health
20	Commonwealth Ombudsman
21	Suicide Prevention Collaborative – Illawarra Shoalhaven
22	ReachOut Australia
23	Federation of Parents and Citizens Association of New South Wales
24	Macquarie University
25	Weave Youth and Community Services
26	Awaken Youth PL
27	batyr Australia Ltd
28	University of Wollongong

29	ACON
30	National LGBTI Health Alliance and Twenty10 inc GLCS NSW
31	3 rd Degree Consulting
32	yourtown
33	Translational Australian Clinical Toxicology Program
34	(Joint) Lifeline Australia, batyr Australia and Orygen
35	Health Education and Training Institute
36	Australian Medical Association New South Wales
37	Hunter Institute of Mental Health
38	Association of Independent Schools NSW
39	YMCA NSW
40	Name Suppressed
41	Black Dog Institute
42	Australian College of Mental Health Nurses
43	headspace
44	Australian Bureau of Statistics
45	Child Death Review Team, NSW Ombudsman
46	NSW Government
47	Advocate for Children and Young People
48	Mission Australia
49	Mental Health Carers NSW Inc.
50	SANE Australia
51	Beyond Blue
52	Youth Action
53	Suicide Prevention Australia
54	Royal Australian and New Zealand College of Psychiatrists
55	Name Suppressed
56	Casula Community Group for Responsible Planning Inc
57	Name Suppressed

Appendix Four – Witnesses

Monday, 27 November 2017

Auditorium, Singleton Youth Venue, Singleton

WITNESS	POSITION	ORGANISATION
Charlie Faulkner	Chairperson	Awabakal Medical Service
Taasha Layer	Chief Executive Officer	Ungooroo Medical Service
Clarinda Masters	Youth Support Officer	Ungooroo Medical Service
Toni Manton	Aboriginal Health Access Officer	Hunter New England Central Coast Primary Health Network
Jaelea Skehan	Director	Everymind
Marc Bryant	Program Manager, Suicide	Everymind
Danielle Adams	Service Manager	The Way Back Service – Hunter Primary Care
Sharnie Everton	Suicide Prevention and Early Intervention Officer	Hunter New England Central Coast Primary Health Network
Todd Heard	Clinical Leader, Aboriginal Psychologist	Wiyiliin Ta - Hunter Child and Adolescent Mental Health Service (CAHMS)
Bala Nagarsekar	Clinical Director, Child and Adolescent Psychiatrist	Child and Adolescent Mental Health Service
Michael DiRienzo	Chief Executive	Hunter New England Local Health District
John Mowatt	Acting Service Director	Child and Adolescent Mental Health Service
Jane Mendelson	Youth Mental Health Coordinator	Hunter New England Central Coast Primary Health Network
Stephen Hirneth	Service Manager	headspace Newcastle – Hunter Primary Care
Felicity Scott	Service Manager	headspace Maitland – Samaritan
Andrea Burns	Secretary	Where There's A Will (Upper Hunter)

Jaclyn Geerin	Aberdeen Town Coordinator	Where There's A Will (Upper Hunter)
Pauline Carrigan	Founder	Where There's A Will (Upper Hunter)
Lisa Whittaker	Learning and Wellbeing Coordinator	Department of Education
Sue Macindoe	Leader – Psychology Practice	Department of Education
Deborah Beckwith	Networked Specialist Centre Facilitator	Department of Education

Monday, 12 February 2018

Preston Stanley Room, Parliament House, Sydney

WITNESS	POSITION	ORGANISATION
Anna Butler	Manager, Domestic Violence Death Review Team	NSW Coroner
James Eynstone-Hinkins	Director, Health and Vital Statistics Section	Australian Bureau of Statistics
Justin Boland	Program Manager, Health and Disability Branch	Australian Bureau of Statistics
Philip Hazell	Independent Member	Child Death Review Team , NSW Ombudsman
Michael Barnes	NSW Ombudsman and Convenor	Child Death Review Team, NSW Ombudsman
Lucinda Brogden	Co-Chair	National Mental Health Commission
Catherine Lourey	Commissioner	NSW Mental Health Commission
Andrew Johnson	Advocate for Children and Young People	Office of the Advocate for Children and Young People
Jo Robinson	Senior Research Officer	Orygen
Vivienne Brown	Senior Policy Analyst	Orygen
Jonathon Nicholas	Chief Executive Officer	ReachOut Australia
Kerrie Buhagiar	Director of Service Delivery	ReachOut Australia
Chris Miller	Principal Consultant	3 rd Degree Consulting
Mark Donkersley	Managing Director	eSafe Global Limited

Monday, 5 March 2018

Jubilee Room, Parliament House, Sydney

WITNESS	POSITION	ORGANISATION
Tracy Adams	Chief Executive Officer	yourtown (Kids Helpline)
Samantha Batchelor	Senior Researcher	yourtown (Kids Helpline)
Alan Woodward	Executive Director	Lifeline Research Foundation
Fiona Shand	Senior Research Fellow and Research Director, LifeSpan	Black Dog Institute
Bridianne O'Dea	Research Fellow	Black Dog Institute
Sarah Lambert	Director, Community Health and Regional Services	AIDS Council of New South Wales
Terence Humphreys	Co-executive Director	Twenty10
Cristyn Davies	Co-Chair	Twenty10
Jason Threthowan	Chief Executive Officer	headspace
Kristen Douglas	National Manager, headspace School Support	headspace
Narelle Corless	NSW Manager, Statewide Services	headspace
Pamela Swinfield	Director Practice Support, Office of the Senior Practitioner	NSW Department of Family and Community Services
Robyn Bale	Relieving Executive Director, Learning and Wellbeing	NSW Department of Education
Pauline Kotselas	Leader of Counselling Services	NSW Department of Education
Anne Reddie	Director, School Services	NSW Department of Education
Murray Wright	NSW Chief Psychiatrist	NSW Ministry of Health
Nigel Lyons	Deputy Secretary, Strategy and Resources	NSW Ministry of Health

Monday, 30 April 2018

Jubilee Room, Parliament House, Sydney

WITNESS	POSITION	ORGANISATION
Pat Dudgeon	Professor, School of Indigenous Studies	University of Western Australia

Appendix Five – Extracts from Minutes

MINUTES OF MEETING No 15

4.35pm, Wednesday, 21 June 2017
Room 1043, Parliament House

Members present

Ms Gibbons (Chair), Mr Tudehope, Ms Cusack, Mr Donnelly, Mr Green, Ms Harrison, and Mr Johnsen

Officers in attendance

Jason Arditi, Emma Matthews, Stephanie Mulvey and Abegail Turingan

1. Next inquiry

Youth Suicide

The Committee had reference to the proposed terms of reference for an Inquiry on the prevention of Youth Suicide as circulated by the Chair.

Discussion ensued.

Resolved, on the motion of Mr Johnsen: That the Committee adopt the following terms of reference for an Inquiry into the prevention of youth suicide:

‘That the Committee on Children and Young People inquire into and report on the current approaches aimed at preventing youth suicide in New South Wales, with particular reference to:

- Any gaps in the coordination and integration of suicide prevention activities and programs across all levels of government
- Governance arrangements and accountabilities for suicide prevention
- Provision of services in local communities, particularly in regional and rural areas
- Provision of services for vulnerable and at-risk groups
- Data collection about the incidence of youth suicide and attempted suicide
- Provision of high-quality information and training to service providers
- Approaches taken by primary and secondary schools
- Any other related matters.’

Resolved, on the motion of Mr Green: That the details of the Inquiry be published on the Committee’s website.

It was agreed that the Chair would issue a media release.

Resolved, on the motion of Mr Donnelly: That the Committee write to stakeholders inviting them to make a submission with a closing date of 31 August 2017.

Mr Johnsen left the meeting.

Mr Tudehope joined the meeting.

2. Confirmation of minutes

Resolved, on the motion of Ms Cusack: That the draft minutes of meeting no 14, held on 25 May 2017, be confirmed.

3. Next meeting

The Committee adjourned at 4.53pm until a date to be determined.

MINUTES of Meeting No 16

1.36pm, Thursday 10 August 2017

Room 1254, Parliament House

Members present

Ms Gibbons (Chair), Mr Tudehope, Ms Harrison, Mr Johnsen, Ms Cusack, Mr Donnelly and Mr Green

Staff present

Jason Arditi, Dora Oravec, Stephanie Mulvey, Mohini Mehta

1. Confirmation of minutes

Resolved, on the motion of Mr Donnelly: That the minutes of the meeting of 21 June 2017 be confirmed.

2. ***

3. ***

4. Inquiry into the Prevention of Youth Suicide

4.1 Submissions received

The Committee agreed that authors of submissions containing sensitive personal admissions should be contacted in order to confirm that they are happy for their submission to be published in full.

Resolved, on the motion of Ms Cusack: That the Committee accept Submissions 1 to 5 and consider publishing submissions at a later date.

4.2 Correspondence

The Committee noted receipt of a letter dated 4 August 2017 from Professor Brin Grenyer, Chair, Psychology Board of Australia, advising that the Board will not be making a submission to the inquiry.

4.3 Draft inquiry timeline

The Committee discussed the proposed timeline and possible locations for site visits and hearing/s.

The Committee agreed to revisit hearings and site visits once submissions had been received.

4.4 Additional stakeholders

Ms Cusack proposed that the Committee write to private health insurers to obtain evidence about the scope of private health coverage in relation to mental health issues.

Discussion ensued.

The Committee agreed to invite private health insurers to make a submission to the inquiry.

5. ***

6. Next meeting

The meeting adjourned at 2.00pm until 1.30pm on 14 September 2017.

MINUTES of Meeting No 17

1.34pm, Thursday 14 September 2017

Room 1254, Parliament House

Members present

Mr Tudehope (Deputy Chair), Ms Harrison, Mr Johnsen, Ms Cusack and Mr Donnelly.

Apologies

Ms Gibbons (Chair) and Mr Green.

Staff present

Simon Johnston, Stephanie Mulvey, Abigail Turingan.

1. Confirmation of minutes

Resolved, on the motion of Mr Donnelly: That the minutes of the meeting of 10 August 2017 be confirmed.

2. Inquiry into the Prevention of Youth Suicide

2.1 Submissions received

Resolved, on the motion of Mr Johnsen: That the Committee authorise the publication of Submissions 1 to 15, 18-30, 32, 34 - 39, 41 – 53 and that the submissions be placed on the Committee website.

Resolved, on the motion of Mr Donnelly: That the Committee authorise the partial publication of Submission 33, with pages 3 – 6 removed.

Resolved, on the motion of Mr Donnelly: That the Committee agree to keep Submissions 17 and 31 confidential and not to publish those submissions.

Resolved, on the motion of Mr Donnelly: That the Committee accept submissions 16 and 40 and resolve to publish those submissions at a later date.

2.2 Location of Inquiry

The Committee considered possible locations for a site visit and hearing.

Discussion ensued.

The Committee identified Singleton and Coffs Harbour as preferred locations for a site visit and hearing. The Committee also discussed the possibility of a round table discussion as a component of a site visit and agreed that the Secretariat should prepare a proposal for site visits and hearings in Singleton and Coffs Harbour.

The Committee noted that the proposed timeframe for site visits and hearing may need to be revisited.

3. ***

4. Next meeting

The meeting adjourned at 1.57pm until a date to be determined.

MINUTES OF MEETING No 18

1.33pm, Thursday 12 October 2017

Room 1254, Parliament House

Members present

Ms Gibbons (Chair) Mr Tudehope, Ms Harrison, Mr Johnsen, Mr Green, Ms Cusack and Mr Donnelly.

Staff present

Simon Johnston, Stephanie Mulvey, Abegail Turingan.

1. Confirmation of minutes

Resolved, on the motion of Ms Cusack: That the minutes of the meeting of 14 September 2017 be confirmed.

2. Inquiry into the Prevention of Youth Suicide

2.1 Submissions received

Resolved, on the motion of Mr Johnsen: That the Committee authorise:

- the publication of Submissions 31, 54 and 56 and that the submissions be placed on the Committee website.
- the publication of Submission 55, with minor amendments as requested by the author, and that the submission be placed on the Committee website.
- the partial publication of Submission 40 and that the submission be placed on the Committee website.

2.2 Correspondence

Committee noted receipt of letter dated 10 October 2017 from Ms Kathy Stevens, Department of Human Services advising that the Department has decided not to make a submission.

2.3 Conduct of inquiry

Committee considered proposal for regional visits and public hearings, including the following options:

(Option A): That the Committee undertake regional visits to and public hearings in the Hunter region (27 November 2017) and the Clarence Valley (28 November 2017).

(Option B): That the Committee undertake a regional visit to and public hearing in the Hunter region on 27 November 2017, and undertake a regional visit to and a public hearing at the Clarence Valley at a later date.

Discussion ensued.

Resolved, on the motion of Mr Johnsen: That the Committee undertake a regional visit to and public hearing in the Hunter region on 27 November 2017, and undertake a regional visit to and a public hearing at the Clarence Valley at a later date.

The Committee agreed that the Committee would travel to Newcastle late on the afternoon of 26 November 2017 and return to Sydney by 6pm on 27 November 2017; and the regional visit to and public hearing in Clarence Valley would occur on 7 December 2017.

3. ***

4. Next meeting

The meeting adjourned at 1.44pm until a date to be determined.

MINUTES OF MEETING No 19

1.33pm, Thursday 16 November 2017

Room 1136, Parliament House

Members present

Ms Gibbons (Chair), Ms Harrison, Mr Johnsen, Mr Green, Ms Cusack and Mr Donnelly.

Apologies

Mr Tudehope.

Staff present

Simon Johnston, Stephanie Mulvey, Abigail Turingan.

1. Confirmation of minutes

Resolved, on the motion of Ms Donnelly, seconded Ms Harrison: That the minutes of the meeting of 12 October 2017 be confirmed.

2. ***

3. **Inquiry into the Prevention of Youth Suicide**

3.1 Submissions received

Resolved, on the motion of Ms Harrison, seconded Mr Donnelly: That the Committee authorise the partial publication of Submission 16 and that the submission be placed on the Committee website.

3.2 Conduct of inquiry

Committee considered revised proposal and list of witnesses for Hunter visit.

Resolved, on the motion of Mr Donnelly, seconded Mr Green: That the Committee hold a public hearing and roundtable discussion in Singleton on 27 November 2017 and hear from relevant witnesses.

Committee reconsidered proposal to conduct hearing on 7 December. Discussion ensued.

Resolved, on the motion of Mr Donnelly, seconded Ms Cusack: That the Committee not hold a public hearing on 7 December 2017.

Resolved, on the motion of Mr Green, seconded Mr Donnelly: That the Committee investigates the possibility of a hearing or site visit to the Lithgow area and an appropriate date for such a hearing or visit.

4. **General business**

The Committee discussed logistical arrangements for the upcoming Singleton hearing. The secretariat will circulate an itinerary to members, including address details.

5. **Next meeting**

The meeting adjourned at 1.53pm until 8.45am on Monday, 27 November 2017 at Singleton Youth Venue.

MINUTES OF MEETING No 20

8.48am, Monday, 27 November 2017

Singleton Youth Venue

Corner Bathurst Street & Pitt Street, Singleton NSW

Members present

Ms Gibbons (Chair), Mr Tudehope, Ms Harrison, Mr Johnsen, Mr Green, Ms Cusack and Mr Donnelly.

Staff present

Simon Johnston, Stephanie Mulvey, Abigail Turingan.

Pre-hearing deliberative

1. Confirmation of minutes (attached)

Resolved, on the motion of Mr Donnelly, seconded Ms Harrison: That the minutes of the meeting of 16 November 2017 be confirmed.

2. Inquiry into the Prevention of Youth Suicide – Singleton hearing and roundtable

2.1 Hearing details

The secretariat has previously circulated a hearing pack containing hard copies of notice of hearing, questions for witnesses, the submissions summary, relevant submissions, and briefing notes.

2.2 Submissions

Committee to consider publication of submission received on 23 November 2017, Submission 57. The author has requested that contact details and name be suppressed.

Resolved, on the motion of Ms Harrison, seconded Mr Johnsen: That the Committee authorise the partial publication of Submission 57, with name suppressed, and that the submission be placed on the Committee website.

2.3 Media orders

Committee to consider permitting the media to record, photograph and broadcast the day's public hearing.

Resolved on the motion of Mr Donnelly, seconded Mr Johnsen: That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 27 November 2017, in accordance with the Legislative Assembly's guidelines for the coverage of proceedings for committees administered by the Legislative Assembly.

2.4 Answers to questions taken on notice

Committee to consider the time within which witnesses should be required to answer any questions taken on notice during the hearing.

Resolved on the motion of Mr Donnelly, seconded Mr Johnsen: That witnesses be requested to return answers to questions taken on notice and supplementary questions within 14 days of the date on which the questions are forwarded to witnesses.

2.5 Publication orders

Committee to consider publishing transcript of evidence, questions on notice and supplementary questions.

Resolved, on the motion of Mr Tudehope, seconded Mr Johnsen: That the corrected transcript of public evidence given today and responses provided to questions taken on notice and supplementary questions be authorised for publication and uploaded on the Committee's website.

2.6 Closed roundtable session

Committee to consider holding closed roundtable session in afternoon following public hearing to hear in private from those with a lived experience of youth suicide.

Resolved, on the motion of Mr Johnsen, seconded Mr Tudehope: That the Committee:

- hold a closed roundtable session following the public hearing to hear in private from those with a lived experience of youth suicide;
- agrees that the closed roundtable session not be recorded, broadcast or photographed.

3. ***

Public hearing and closed roundtable session

4. Public hearing

The public hearing opened at 9.05am. Witnesses and the public were admitted.

Charlie Faulkner, Chairperson, Awabakal Medical Service, sworn and examined.

Taasha Layer, Chief Executive Officer, Ungooroo Medical Service, affirmed and examined.

Clarinda Masters, Youth Support Officer, Ungooroo Medical Service, affirmed and examined.

Toni Manton, Aboriginal Health Access Officer, Hunter New England Central Coast Primary Health Network, affirmed and examined.

Evidence concluded, the witnesses withdrew.

Dr Jaelea Skehan, Chief Executive Officer, Everymind, affirmed and examined.

Marc Bryant, Program Manager, Suicide, Everymind, sworn and examined.

Danielle Adams, The Way Back Service – Hunter Primary Care, affirmed and examined.

Sharnie Everton, Suicide Prevention and Early Intervention Officer, Hunter New England Central Coast Primary Health Network, affirmed and examined.

Evidence concluded, the witnesses withdrew. The hearing adjourned at 10.48 and resumed at 11.05.

Todd Heard, Clinical Leader, Aboriginal Psychologist, Wiyiliin Ta, Child and Adolescent Mental Health Service, affirmed and examined.

Dr Bala Nagarsekar, Clinical Director, Child and Adolescent Psychiatrist, Child and Adolescent Mental Health Service, affirmed and examined.

Michael DiRienzo, Chief Executive, Hunter New England Local Health District, affirmed and examined.

John Mowatt, Acting Service Director, Child and Adolescent Mental Health Service, affirmed and examined.

Jane Mendelson, Youth Mental Health Coordinator, Hunter New England Central Coast Primary Health Network, affirmed and examined.

Evidence concluded, the witnesses withdrew.

Stephen Hirneth, Service Manager, Headspace Newcastle – Hunter Primary Care, affirmed and examined.

Felicity Scott, Service Manager, Headspace Maitland – Samaritan, sworn and examined.

Pauline Carrigan, Founder, Where There's a Will (Upper Hunter), sworn and examined.

Andrea Burns, Secretary, Where There's a Will (Upper Hunter), sworn and examined.

Jaclyn Geerin, Aberdeen Town coordinator, Where There's a Will (Upper Hunter), sworn and examined.

Evidence of Felicity Scott and Stephen Hirneth concluded, and those witnesses withdrew.

Lisa Whittaker, Learning and Wellbeing Coordinator, Department of Education, affirmed and examined.

Sue Macindoe, Leader – Psychology Practice, Department of Education, affirmed and examined.

Deborah Beckwith, Networked Specialist Centre Facilitator, Department of Education, affirmed and examined.

The examination of Pauline Carrigan, Andrea Burns and Jaclyn Geerin continued under former oath.

The public hearing concluded at 1.09pm. Witnesses and public withdrew.

5. Closed roundtable session

The Committee resumed at 1.30pm, holding a closed roundtable session with people with lived experience of suicide in the Hunter region. A counsellor was present for support.

6. Next meeting

The meeting adjourned at 3pm until a date to be determined.

MINUTES OF MEETING No 21

12.01pm, Wednesday 17 January 2018

Room 813 or via teleconference

Members present

Ms Gibbons (Chair), Ms Harrison, Mr Johnsen, Ms Cusack and Mr Donnelly.

Apologies

Mr Tudehope and Mr Green.

Staff present

Elaine Schofield, Emma Wood, Stephanie Mulvey and Abegail Turingan.

1. Confirmation of minutes

Resolved, on the motion of Mr Donnelly, seconded Ms Harrison: That the minutes of the meeting of 27 November 2017 be confirmed.

2. ***

3. Inquiry into the prevention of youth suicide

3.1 Answers to questions taken on notice and supplementary questions from Singleton hearing

The Committee noted that the following answers to questions taken on notice and supplementary questions had been received:

- Way Back Support Service
- Department of Education
- NSW Health, including Wiyiliin Ta and CAMHS
- Hunter New England PHN
- Everymind
- Headspace Maitland and Newcastle

Resolved, on the motion of Ms Harrison, seconded Mr Donnelly: That the answer to item 3.3 of the response to supplementary questions provided by CAMHS, NSW Health not be published.

3.2 Conduct of inquiry

Resolved, on the motion of Mr Donnelly, seconded Mr Johnsen: That the Committee hold two public hearings at Parliament House on Monday 12 February and on a date to be determined, and hear from relevant witnesses.

4. ***

5. ***

6. Next meeting

The meeting adjourned at 12.28pm until 9.15am on Monday, 12 February 2018.

MINUTES OF MEETING No 22

9.15am, Monday, 12 February 2018

Preston Stanley Room

Parliament of New South Wales

Members present

Mr Tudehope (Deputy Chair), Ms Harrison, Mr Johnsen, Mr Green and Mr Donnelly.

Apologies

Ms Gibbons (Chair).

Staff present

Jonathan Elliott, Elaine Schofield, Emma Wood Stephanie Mulvey, Abigail Turingan.

Pre-hearing deliberative

1. Confirmation of minutes (attached)

Resolved, on the motion of Mr Johnsen, seconded Ms Harrison: That the minutes of the meeting of 17 November 2017 be confirmed.

2. ***

3. Inquiry into the Prevention of Youth Suicide

3.1 Media orders

Committee to consider permitting the media to record, photograph and broadcast the day's public hearing.

Resolved on the motion of Mr Johnsen, seconded Mr Green: That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 12 February 2018, in accordance with the Legislative Assembly's guidelines for the coverage of proceedings for committees administered by the Legislative Assembly.

3.2 Answers to questions taken on notice

Committee to consider the time within which witnesses should be required to answer any questions taken on notice during the hearing.

Resolved on the motion of Mr Donnelly, seconded Mr Johnsen: That witnesses be requested to return answers to questions taken on notice and supplementary questions within 14 days of the date on which the questions are forwarded to witnesses.

3.3 Publication orders

Committee to consider publishing transcript of evidence, questions on notice and supplementary questions.

Resolved, on the motion of Mr Johnsen, seconded Mr Donnelly: That the corrected transcript of public evidence given today and responses provided to questions taken on notice and supplementary questions be authorised for publication and uploaded on the Committee's website.

Public hearing

4. Public hearing

The public hearing opened at 9.25am. Witnesses and the public hearing were admitted.

Anna Butler, Manager, Domestic Violence Review Team, NSW Coroner's Court, affirmed and examined.

Evidence concluded, the witness withdrew.

Mr James Eynstone-Hinkins, Director, Health and Vital Statistics Section, Australian Bureau of Statistics affirmed and examined.

Ms Justine Boland, Program Manager, Australian Bureau of Statistics, affirmed and examined.

Evidence concluded, the witnesses withdrew. The hearing adjourned at 11.04am and resumed at 11.25am.

Mr Michael Barnes, NSW Ombudsman, Child Death Review Team - Convenor, affirmed and examined.

Professor Philip Hazell, sworn and examined.

Evidence concluded, the witnesses withdrew.

Ms Catherine Lourey, Commissioner, NSW Mental Health Commission, affirmed and examined.

Ms Lucinda Brogden, Co-Chair, National Health Commission, affirmed and examined.

Evidence concluded, the witnesses withdrew. The hearing adjourned at 1.12pm and resumed at 2.01pm.

Mr Andrew Johnsen, The Advocate for Children and Young People, affirmed and examined.

Evidence concluded and the witness withdrew.

Dr Jo Robinson, Head of Youth Suicide Prevention Research at Orygen, the National Centre for Excellence in Youth Mental Health, affirmed and examined.

Ms Vivienne Brown, Senior Policy Analyst at Orygen, the National Centre for Excellence in Youth Mental Health, sworn and examined.

Evidence concluded, the witnesses withdrew. The hearing adjourned at 3.27pm and resumed at 3.45pm.

Mr Jonathan Nicholas, CEO of ReachOut Australia, affirmed and examined.

Dr Kerrie Buhagiar, Director, ReachOut Australia, sworn and examined.

Evidence concluded, the witnesses withdrew.

Mr Mark Donkersley, Managing Director eSafe Global, sworn and examined.

Mr Chris Miller, Principal Consultant at 3rd Degree Consulting, sworn and examined.

The public hearing concluded at 5.08pm. Witnesses and public withdrew.

5. ***

6. Next meeting

The meeting adjourned at 5.10pm until Monday, 5 March 2018.

MINUTES OF MEETING No 22

9.20am, Monday, 5 March 2018

Jubilee Room

Parliament of New South Wales

Members present

Mr Tudehope (Deputy Chair), Ms Harrison, Mr Fang, Mr Green and Mr Donnelly.

Apologies

Ms Gibbons (Chair), Mr Johnsen.

Staff present

Elaine Schofield, Emma Wood, Stephanie Mulvey, Abigail Turingan.

1. Deliberative meeting

1.1 Confirmation of minutes (attached)

Resolved, on the motion of Mr Donnelly, seconded Ms Harrison: That the minutes of the meeting of 12 February 2018 be confirmed.

1.2 Committee membership

The Committee noted that on Tuesday 13 February 2018, the Hon Wes Fang MLC was appointed to the Committee on Children and Young People in place of the Hon Catherine Cusack MLC: Legislative Council, Minutes No 138, Item 38; Legislative Assembly, Votes and Proceedings No 157, Item 25.

1.3 ***

1.4 ***

2. Inquiry into the Prevention of Youth Suicide

2.1 Media orders

Resolved on the motion of Mr Fang, seconded Ms Harrison: That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearing on 5 March 2018, in accordance with the Legislative Assembly's guidelines for the coverage of proceedings for committees administered by the Legislative Assembly.

2.2 Answers to questions taken on notice

Resolved on the motion of Mr Donnelly, seconded Mr Fang: That witnesses be requested to return answers to questions taken on notice and supplementary questions within 14 days of the date on which the questions are forwarded to witnesses.

2.3 Publication orders

Resolved, on the motion of Mr Fang, seconded Mr Donnelly: That the corrected transcript of public evidence given today and responses provided to questions taken on notice and supplementary questions be authorised for publication and uploaded on the Committee's website.

3. Public hearing

Witnesses and the public were admitted. The Chair opened the public hearing at 9.32am and after welcoming the witness made a short opening statement.

Mr Alan Woodward, Executive Director, Lifeline Research Foundation, was sworn and examined.

Ms Samantha Batchelor, Senior Researcher, YourTown, was affirmed and examined.

Ms Tracy Adams, Chief Executive Officer, YourTown, was sworn and examined.

Mr Woodward and Ms Batchelor each made an opening statement.

Evidence concluded, the witnesses withdrew.

Dr Fiona Shand, Senior Research Fellow and Research Director, LifeSpan, Black Dog Institute was affirmed and examined.

Dr Bridianne O'Dea, Research Fellow, Black Dog Institute, was affirmed and examined.

Dr Shand made an opening statement.

Evidence concluded, the witnesses withdrew. The hearing adjourned at 11.00am and resumed at 11.16am.

Ms Sarah Lambert, Director, Community Health and Regional Services, AIDS Council of New South Wales, was affirmed and examined.

Ms Cristyn Davies, Co-Chair, and Terence Humphreys, Co-Executive Director, Twenty 10, were affirmed and examined.

Ms Davies and Ms Lambert each made an opening statement.

Evidence concluded, the witnesses withdrew.

Mr Jason Trethowan, Chief Executive Officer, and Ms Narelle Corless, NSW Manager, State-wide Services, Headspace, were sworn and examined.

Ms Kristen Douglas, National Manager, School Support, Headspace, was affirmed and examined.

Mr Trethowan and Ms Douglas each made an opening statement.

Evidence concluded, the witnesses withdrew. The hearing adjourned at 12.50pm and resumed at 2.31pm.

Ms Pam Swinfield, Director, Practice Support, Northern Cluster, Office of the Senior Practitioner, NSW Department of Family and Community Services, was affirmed and examined.

Ms Swinfield made an opening statement.

Evidence concluded, the witness withdrew. The hearing adjourned at 3.20pm and resumed at 3.30pm.

Ms Robyn Bale, R/Executive Director, Learning and Wellbeing, Ms Pauline Kotselas, Leader of Counselling Services, and Ms Anne Reddie, Director, School Services, NSW Department of Education, were sworn and examined.

Ms Bale made an opening statement.

Evidence concluded, the witnesses withdrew.

Dr Murray Wright, Chief Psychiatrist and Dr Nigel Lyons, Deputy Secretary, Strategy and Resources, NSW Ministry of Health, were sworn and examined.

Dr Lyons made a short opening statement.

The public hearing concluded at 5.02pm. Witnesses and public withdrew.

4. Post-hearing deliberative

The Committee commenced a deliberative meeting at 5.03pm.

4.1 Acceptance and publication of tendered documents

Resolved, on the motion of Mr Donnelly, seconded Ms Harrison, that the Committee accept the following documents:

- Geospatial maps provided by Black Dog Institute of Suicide Deaths between the years 2006 – 2017

4.2 Redaction of material in transcript

Resolved, on the motion of Mr Fang, seconded Mr Donnelly, that references to information identifying children and young people who have died by suicide in the transcript of 5 March 2018 not be published.

4.3 General business

Members may have supplementary questions that they wish to send to witnesses from today's hearing or the previous hearing. Members to send their questions to Secretariat by COB Friday.

5. Next meeting

The meeting adjourned at 5.05pm until Monday, 30 April 2018.

MINUTES OF MEETING No 24

12.47pm, Monday 30 April 2018

Jubilee Room

Parliament of New South Wales

Members present

Ms Gibbons (Chair) Mr Tudehope (Deputy Chair), Ms Harrison, Mr Fang, Mr Johnsen, Mr Green (from 1.05pm), Mr Donnelly (from 2.20pm).

Staff present

Elaine Schofield, Emma Wood, Stephanie Mulvey, Abegail Turingan

1. Confirmation of minutes

Resolved, on the motion of Mr Tudehope, seconded Ms Harrison: That the minutes of the meeting of 5 March 2018 be confirmed.

2. Inquiry into the prevention of youth suicide

2.1 Correspondence

Resolved, on the motion of Mr Johnsen, seconded Mr Fang: That the Committee note the following correspondence received:

- 19 and 20 March 2018 – Emails from Amanda Riedel, CEO and Founder of the Harrison Riedel Foundation regarding an app and website the Foundation has developed for young people in distress.

2.2 Redaction of 5 March public hearing transcript

Resolved, on the motion of Mr Fang, seconded Ms Harrison: That the Committee agrees with the request from Headspace to keep parts of the transcript of their evidence on 5 March 2018 confidential and not be published.

2.3 Answers to questions taken on notice at the public hearings on 12 February and 5 March

Resolved, on the motion of Mr Fang, seconded Mr Johnsen: That the case studies on pages 4 – 9 of the NSW Coroner's response to questions taken on notice remain confidential to the Committee and not be published.

3. ***

4. Pre hearing resolutions for the following public hearings:

- Inquiry into the prevention of youth suicide; and
- ***

4.1 Media orders

Resolved, on the motion of Mr Fang, seconded Mr Johnsen: That the Committee authorises the audio-visual recording, photography and broadcasting of the public hearings on 30 April 2018, in accordance with the Legislative Assembly's guidelines for the coverage of proceedings for committees administered by the Legislative Assembly

4.2 Answers to questions taken on notice

Resolved, on the motion of Mr Johnsen, seconded Mr Fang: That witnesses be requested to return answers to questions taken on notice within 14 days of the date on which the questions are forwarded to witnesses

4.3 Publication orders for today's public hearings

Resolved, on the motion of Mr Johnsen, seconded Mr Fang: That the corrected transcripts of public evidence given today be authorised for publication and uploaded on the Committee's website

4.4 Additional questions

Resolved, on the motion of Mr Johnsen, seconded Mr Fang:

That the Committee adopts the following process for sending additional questions to witnesses:

1. Members submit additional questions to the Secretariat by close of business two full working days after the transcripts are distributed to members.
2. The proposed additional questions will be circulated to all members.
3. Members may express concerns or objections to additional questions within 2 working days of distribution of the questions from the secretariat, any objections that cannot be resolved will be deferred until a deliberative meeting of the Committee.

5. Public hearing – Inquiry into prevention of youth suicide

The witness was admitted via teleconference. The Chair opened the public hearing at 1.00pm and after welcoming the witness made a short opening statement.

Professor Patricia Dudgeon, School of Indigenous Studies, University of Western Australia, was affirmed, before making a short opening statement.

The Committee commenced questioning the witness.

Mr Green left the room at 1.35pm.

The public hearing concluded at 1.36pm. The witness withdrew from the teleconference.

Mr Tudehope left the room at 1.40pm.

6. ***

Mr Tudehope entered the room at 2.44pm.

7. General business

The Chair officially welcomed Mr Fang to the Committee and also thanked the Deputy Chair for acting as Chair during the Chair's short period of absence.

8. Next meeting

The meeting adjourned at 3.45pm until a date to be determined.

UNCONFIRMED MINUTES OF MEETING No 26

Friday 19 October 2018

10.32am, Room 1043

Members present

Ms Gibbons (Chair), Mr Tudehope, Mr Donnelly, Mr Fang, Mr Green, Ms Harrison and Mr Johnsen.

Staff present

Elaine Schofield, Emma Wood, Stephanie Mulvey, Abegail Turingan

Apologies

None

1. Confirmation of minutes

Resolved, on the motion of Mr Tudehope, seconded Mr Donnelly: That the minutes of the meeting of 15 August 2018 be confirmed.

2. ***

3. Inquiry into prevention of youth suicide

3.1 Publication of answers received to supplementary questions

Resolved, on the motion of Mr Donnelly, seconded Mr Tudehope: That the answers received from the Ministry of Health to the supplementary questions be published and placed on the Committee's website.

3.2 Consideration of Chair's draft report

Resolved, on the motion of Mr Donnelly, seconded Mr Fang: That the draft report be considered chapter by chapter.

Chapter One

Resolved, on the motion of Ms Harrison, seconded Mr Donnelly: That Chapter One stand part of the report.

Chapter Two

Resolved, on the motion of Mr Johnsen, seconded Ms Harrison: That recommendation 6 be amended to insert ',implement and monitor' after 'develop'.

Resolved, on the motion of Mr Fang, seconded Ms Gibbons: That recommendation 9 be amended to omit 'provide funding to' and insert 'support' before 'research'.

Resolved, on the motion of Mr Johnsen, seconded Mr Green: That recommendation 10 be amended to omit 'of what is acceptable' after 'set a minimum standard'.

Resolved, on the motion of Mr Fang, seconded Ms Gibbons: That recommendation 13 be amended to omit 'fund' and insert 'support' before 'research into suicide prevention'.

Resolved, on the motion of Mr Donnelly, seconded Mr Fang: That a new recommendation 14 be inserted after recommendation 13 which reads:

'Recommendation 14

The Committee recommends that the NSW Government makes a request to NSW Health to undertake and publish a comprehensive international literature search of peer review research into what have been evaluated as the most successful suicide prevention programs for children and young people.'

Resolved, on the motion of Mr Johnsen, seconded Mr Fang: That Chapter Two, as amended, stand part of the report.

Chapter Three

Resolved, on the motion of Mr Donnelly, seconded Mr Fang: That paragraph 3.72 be amended to omit 'other' before 'vulnerable groups' and ',such as LGBTIQ and male young people,' before 'may especially benefit from co-design.'

Resolved, on the motion of Mr Fang, seconded Ms Harrison: That Chapter Three, as amended, stand part of the report.

Chapter Four

Resolved, on the motion of Mr Fang, seconded Mr Johnsen: That Chapter Four stand part of the report.

Chapter Five

Resolved, on the motion of Mr Fang, seconded Mr Johnsen: That paragraph 5.29 be amended to omit:

'The Committee notes the evidence that the link between bullying on social media and suicide risk in young people may be overstated. However, given that it is still an emerging area, the committee considers that it is important to conduct further research into the impact of social media on youth suicide.'

and replace with:

'The Committee acknowledges the lack of evidence that there is a link between bullying on social media and suicide risk in young people. However, the Committee notes that it is one risk factor to consider in a complex, multi-issue area and should be addressed through systematic, evidence based measures to reduce bullying and its harms.

Given that it is still an emerging area, the Committee considers that it is important to conduct further research into the impact of social media on youth suicide.'

Resolved, on the motion of Ms Gibbons, seconded Mr Donnelly: That recommendation 21 be amended to omit 'fund' and insert 'support' before 'research into the impact of social media on youth suicide.'

Resolved on the motion of Mr Green, seconded Mr Fang: That the report be amended to insert new paragraph 5.75 which reads:

'The Committee recognises the valuable contribution that school counsellors, nurses, chaplains and special religious education plays in providing assistance and support to children. They have an important role in providing children an opening or opportunity to have conversations about their wellbeing.'

Resolved, on the motion of Mr Johnsen, seconded Mr Green: That recommendation 25 be amended to insert 'and efficacy' after 'adequacy'.

Resolved, on the motion of Mr Fang, seconded Ms Harrison: That Chapter Five, as amended, stand part of the report.

Executive Summary

Resolved, on the motion of Mr Donnelly, seconded Mr Tudehope: That the Executive Summary stand part of the report.

Committee Report

Resolved, on the motion of Mr Tudehope, seconded Mr Fang:

1. That the draft report, as amended, be the report of the Committee, and that it be signed by the Chair and presented to the House
2. That the Chair and committee staff be permitted to correct stylistic, typographical and grammatical errors.
3. That, once tabled, the report be posted on the Committee's website.

4. Other business

The Committee thanked The Hon Catherine Cusack MLC and Mr Michael Johnsen MP for their advocacy to undertake the Inquiry into the prevention of youth suicide.

5. Next meeting

The meeting adjourned at 11.56am until a date to be determined.

Appendix Six – Glossary

ABS	Australian Bureau of Statistics
ACCHS	Aboriginal Community Controlled Health Services
AbSec	Aboriginal Child, Family and Community Care State Secretariat
AISNSW	Association of Independent Schools NSW
ATR	Australian Trauma Registry
ATSI	Aboriginal and Torres Strait Islander
ATSIPEP	Aboriginal and Torres Strait Islander Suicide Prevention Evaluation Project
CDRT	NSW Child Death Review Team
COAG	Council of Australian Governments
CRESP	Centre for Research Excellence in Suicide Prevention
DVRT	Domestic Violence Review Team
FACS	Department of Family and Community Services
Fifth Plan	Fifth National Mental Health and Suicide Prevention Plan
HATS	Hunter Area Toxicology Service
ICD	International Classification Diseases
KPI	Key Performance Indicators
LGBTIQ	Lesbian, Gay, Bisexual, Transgender, Intersex, Queer
LHD	Local Health District
LHN	Local Hospitals Network
MHDAPC	Mental Health Drug and Alcohol Principal Committee
NCIS	National Coronial Information System
NHMRC	National Health and Medical Research Council
NMHC	National Mental Health Commission
NSPS	National Suicide Prevention Strategy
NSPT	National Suicide Prevention Trials
NSW MHC	Mental Health Commission NSW
OOHC	Out of home care
PDHPE	Personal Development, Health and Physical Education
PHN	Primary Health Network
QPR	Question, Persuade, Refer
RANZCP	Royal Australian and New Zealand College of Psychiatrists

SPAG	Suicide Prevention Advisory Group
SPN	Suicide Prevention Network
TAFE	Technical and Further Education
WAC SIS	West Australian Coronial Suicide Information System

Appendix Seven – Terminology

Glossary of following terms obtained from the Beyond Blue [submission](#) and the Life In Mind Australia [webpage](#).

Attempted suicide: Any non-fatal suicidal behaviour. In some cases it can be difficult to determine if a person intended their actions to result in death.

Best practice: The procedures or programs that have been shown by evidence (such as research or results over time) to be the most effective or to achieve optimal outcomes.

Evidence-based programs: Programs that have undergone rigorous scientific evaluation or are based on demonstrated experience or information extracted from scientific literature.

Gatekeeper: Those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine.

Gatekeeper training: Training provided to gatekeepers to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate.

Help-seeking behaviour: The process of a person actively asking for help or support in order to cope with adverse circumstances or problems. Help-seeking behaviour involves being able to recognise and express symptoms or problems as well as an understanding of how to access support and a willingness to do so.

Intervention: Actions or activities taken to improve a person or groups of people's health and wellbeing to prevent negative outcomes or to change the course of an existing condition. Interventions generally work to decrease risk factors or increase protective factors, and may target the whole of a population (universal), specific groups or segments of the population at higher risk for a particular problem (selective) or individuals who are showing early signs for mental ill-health or suicide (indicated).

Lived experience: Personal experience of or caring for or otherwise supporting someone with mental illness; or personal experience of suicide, suicidal thoughts or a suicide attempt; or personal experience of caring for someone during suicidal crisis, bereavement by suicide or being touched by suicide in another way.

Mental health: Positive concept relating to resilience, enjoyment of life and social connection. This state of wellbeing increases the ability of individuals and communities to realise goals and potential, to cope with the normal stresses of everyday life, to work productively and to contribute to society.

Mental health problem: A mental health problem diminishes a person's cognitive, emotional or social abilities but not to the extent that it meets the criteria for a mental illness diagnosis.

Mental illness: A mental illness is a clinically diagnosed disorder that significantly interferes with a person's cognitive, emotional or social abilities. Examples include anxiety disorders, depression, bipolar disorder, eating disorders and schizophrenia.

Postvention: The intervention activities that are conducted after a suicide to help people to cope with the loss and increase their resilience. These activities usually target family, friends, professionals, community members and others bereaved by the suicide, who may all be at an increased risk of suicide themselves.

Recovery: A process, sometimes ongoing and lifelong, defined and led by the person involved, through which they can achieve independence, self-esteem and a meaningful and contributing life in the community.

Risk factors: Characteristics, relationships, circumstances or events that can increase the likelihood of suicidal behaviour.

Safety Plan: A structured plan – ideally developed with support from a health professional or someone trusted – that an individual can work through when they're experiencing suicidal thoughts, feelings, distress or crisis.

Self-harm: A person intentionally causing pain or damage to their own body. This behaviour may be motivated by suicidal intent or non-suicidal intent (for example, as a way of expressing or controlling distressing feelings or thoughts).

Stigma: The negative opinions or stereotypes about particular characteristics, behaviours or illnesses that causes someone to exclude, shame or devalue a person or group of people. Negative attitudes create prejudice which leads to negative actions and discrimination.

Suicidal behaviours: Includes thinking about or planning a suicide (suicidal ideation), attempting suicide or a person taking their own life.

Suicidal crisis: A situation in which a person is attempting to kill themselves or is seriously contemplating or planning to do so.

Suicidal ideation: A person having thoughts of ending their own life. These thoughts may vary in intensity and duration from fleeting thoughts to a complete preoccupation with wanting to die. Although not all suicidal thoughts lead a person to suicide or attempt suicide, suicidal ideation should always be taken seriously.

Suicide: The act of deliberately ending one's life. In some cases it can be difficult to determine if a person intended their actions to result in death.

Suicide rate: The proportion of deaths resulting from suicide, compared to the total number of deaths over a given time frame.

Trauma: The mind or body's reactions to an intense, stressful or shocking experience that exceeds that person's ability to cope, with the potential for people to react differently to similar life events based on their previous exposure, background and other risk factors. A person does not need to witness a distressing event by may experience trauma after hearing about the event, in dealing with its effects on others or through mechanisms like epigenetics where the trauma experienced by parents can affect their unborn children.

Warning signs: Behaviours that may indicate a person has an increase or imminent risk of suicide. Warning signs may include but are not limited to behaviours such as talking about suicide, giving away possessions, or withdrawing from relationships or regular activities.