REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

INQUIRY INTO PREVENTION OF YOUTH SUICIDE IN NEW SOUTH WALES

At Singleton on Monday 27 November 2017

The Committee met at 9.00 a.m.

PRESENT

Ms M. Gibbons (Chair)

The Hon. C. Cusack
The Hon. G. Donnelly
The Hon. P. Green
Ms J. Harrison
Mr M. Johnsen
Mr D. Tudehope (Deputy Chair)

The CHAIR: Good morning everyone. I declare this hearing of the Committee on Children and Young People open. Thank you all for coming today. Before giving a brief outline of the day, I acknowledge and pay respect to the traditional owners and custodians of this land, the Wanaruah people, and their elders past and present. Today the Committee will be hearing from a wide range of people who are working to prevent youth suicide in the Hunter region and across the country. The day is meant to be informal, and is an opportunity for the Committee to learn from those on the ground about what is working in the area of youth suicide prevention and what can be done better.

Youth suicide is a big issue for Aboriginal and Torres Strait Islander young people, so it is fitting that we will be starting the day by hearing from experts and service providers in this area. We will then hear from Everymind, formerly the Hunter Institute for Mental Health, a research and policy body based in Newcastle. We will learn about a number of important suicide prevention trials in the Hunter, including LifeSpan. The Committee will also hear from staff from the local Child and Adolescent Mental Health Service, which is part of NSW Health. We will then hear from the headspace centres at Newcastle and Maitland, along with Where There's a Will, a charity delivering mental health first aid programs in the Upper Hunter region. The final session will be an opportunity to speak with key staff from the Department of Education who are working in different ways to prevent youth suicide in the region.

This is an important but sensitive subject, and an issue that I know may affect people in the room personally. The Committee is very aware of this. I encourage you to contact Lifeline on 13 11 14 or Kids Helpline on 1800 55 1800 if you or someone you know needs help. Before we begin, I ask that everyone turn their phones to silent. I now welcome representatives from Everymind, LifeSpan Newcastle, The Way Back Support Service (Hunter Primary Care), and the Hunter Primary Health Network. Thank you all for appearing before the Committee on Children and Young People today to give evidence. Please first state your full name and position, and then take the oath or make an affirmation.

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

The CHAIR: Would any of you like to make a brief opening statement before the commencement of questions? If not, we will move to questions.

The Hon. GREG DONNELLY: Can you comment on the changes that you have observed over time or that you are aware of with Indigenous young people and suicide or attempted suicide? The Committee is trying to grasp a number of things, which include an historical perspective about how things are going. From your own experience and perhaps from working with others, including elders and others in the community, is it something that is getting worse? Is there a sense of stability or are there some bright lights that are opening up possibilities to help young Indigenous people to deal with the problems they have that lead to these issues? Can you give the Committee some perspective?

Mr FAULKNER: Yes. I have been a mental health employee for 14 years. The gap is now different. When we first started, suicide was not on the radar for Indigenous young people, and especially the young boys I work with. Over the past six or seven years there has been a real increase. I have a sense that there is a real gap in knowledge in parents and children about where they can get support. That is the loss from where we used to be to where we are now.

The Hon. GREG DONNELLY: You have 14 years of experience in this field, which is one and a half decades, and you have observed an increase in that time.

Mr FAULKNER: Absolutely. There has been a huge increase. Instead of staying in the community or in family houses, a lot of our kids are being put into the hospital system, which is a jail system. A lot of our kids who end up in hospital often become repeat offenders. Inpatient units are the nexus in Newcastle. Once our young people attend an inpatient unit they tend to go back three to five times.

The Hon. GREG DONNELLY: Have you gathered any insights over that period about what may be contributing to this increase? I direct that question to everyone.

Ms LAYER: I am not a caseworker, but as a general practice we have being conducting Medicare item 715 Aboriginal health assessments within the school system.

The Hon. GREG DONNELLY: What does that mean?

Ms LAYER: It is a comprehensive health assessment. But part of that is a social and mental wellbeing component questionnaire. When we did it with the students at one local high school the feedback was that about 70 per cent identified with some form of mental health issue. It could be mild anxiety, or some issue that the general practitioners obviously wanted to follow up. It was a referral pathway. A lot of the feedback from the teachers was about the family unit and lack of support within that unit that was a creating issues for those young ones. That is what we observed from the 715 health assessments.

The Hon. GREG DONNELLY: The young ones are identifying dysfunction and problems at home within their family as the cause of their anxiety?

Ms LAYER: Yes.

The Hon. GREG DONNELLY: And a number of them are doing that?

Ms LAYER: Yes.

The Hon. GREG DONNELLY: Is that your experience?

Ms MASTERS: I support that. I work in the homelessness sector and I do not think we have a young person on our books who does not have some form of mental health issue. We refer on. Our role is to identify that and make the referral. Whether they access that support is a different story. Accessing the support is a barrier. It is quite significant in our homelessness cohort, and it stems from their housing situation—their accommodation.

The Hon. PAUL GREEN: Can you clarify or define what is a mental health issue, in terms of what you were just saying. It is so broad that I want, for the sake of this inquiry, to narrow the definition. How are you defining that?

Ms MASTERS: The most predominant mental illnesses are depression and anxiety. We see a lot of self harm. We have seen a significant amount of suicide attempts. There are lots of trauma based issues that we refer straight on, because that is not our speciality. I am trying to be very careful because I do not want to speak outside my lane. There is lots of trauma based stuff that is manifesting in different ways, but predominantly depression, anxiety and self-harm.

The CHAIR: Mr Faulkner, you mentioned the hospital system. What can be done to improve the hospital system or are there better places for these young people to be given treatment or assistance?

Mr FAULKNER: That is a really good question. At this stage I do not think there is a better system but the only system we have is another institution. Aboriginal people and Aboriginal young people do not cope with institutions very well at all. Part of our issue is thinking about the step between the community team and the hospital. What is the difference? What is the something that we need in the middle of that? If we find that answer it will help some of our kids, for sure. They do not cope in hospitals.

I find it difficult—and I work in the system—to go to hospital. When I go to visit young people who are in the institute I find you have to go through three or four doors before you can get in. You have to sign in. You have to look through glass. It feels like a jail. When families come to visit they cannot until 3 o'clock in the afternoon. So the kids do not get to see their mums and dads and the rest of the family until after three. That is not good enough. It feels like and institution. All we are doing is reinventing the wheel—from justice and juvenile justice to hospitals, and that is not great.

The CHAIR: What you have just said is helpful. Thank you.

Mr MICHAEL JOHNSEN: Mr Faulkner you said a little earlier that you believe there is a gap between parents and children about the services available. What do you mean by the gap between the parents and children about the services that are available?

Mr FAULKNER: Parents are also scared of institutions, and scared of us. There is a gap between them understanding about getting help and supporting the young person. That is the gap. Our programs only focus on Indigenous people. We still struggle because parents are scared of what might happen—what we might have to do: for example, we contact Community Services or do all these other things. That is, again, institutes coming in to take control of their children. That is the gap. It is about helping them understand that we are here to help; we are not here to remove anyone. My evidence says that in 2017 we still take away more kids than we did during the stolen generation. What are we doing wrong? The evidence is out there. It has been written about quite a lot, and it is quite strong. So I think we have to really fix that.

The Hon. CATHERINE CUSACK: I just want to come back to the issue of trauma as a cause of depression and this sense that Indigenous culture and history makes these kids more vulnerable. I would like to ask, firstly, about the number of elders in local Aboriginal communities. Is the number of elders declining due to a lower life expectancy?

Mr FAULKNER: From my experience, yes; unfortunately we are. The other thing about it is that we do not get taught anymore, because our elders have passed away. The gap is going to get bigger again because we are not getting taught the things that we need to be taught to support our young people as they grow up. That is a huge gap for us, as well. Closing the gap, keeping our old people alive is a huge issue for us. Yes.

Ms LAYER: Probably, locally, in the last 12 to 18 months, we have had six local elders pass away. That is a lot of culture and history gone—that cannot be passed on. As Charlie said, they have not been replaced, so it is an issue.

The Hon. CATHERINE CUSACK: Yes. I remember being told some time ago that communities were going to be in trouble because of this issue with the elders. Is there any solution to that? I am sorry to ask such a hard question.

Ms LAYER: You guys can correct me if I am wrong but there are small means of people trying to capture that. We do something locally here, which has become very significant: that is elders' morning teas at the high school. We introduce the kids coming to the elders' morning teas. It is only a small gesture, but it is a thing that carries a lot of weight. It creates a real mutual respect between the younger generation and the elders, and the elders can pass on that knowledge. So we have found that locally effective in Singleton. That could be done on a broader scale. We have spoken a lot about it but time is running out. We have to be proactive to make that an intrinsic part of community.

The Hon. CATHERINE CUSACK: The Government submission talks about monitoring mental health and suicide rates amongst Aboriginal people. Are you familiar with any initiatives that have been taken to gather that data and report upon it? It is not a trick question. Are you aware of it; it is in the submission?

Mr FAULKNER: No.

The Hon. CATHERINE CUSACK: Is there any distinction between biological issues for mental health and trauma issues, that you are aware of? Is there any monitoring of the two separate figures for mental health problems?

Mr FAULKNER: They are connected—absolutely. Trauma is connected to our communities. We are only one generation past genocide, really, so it is not that far apart. Trauma is still a huge issue, because most of our families struggle with trauma. That just compounds the issues that are happening every day. It does not get any smaller.

The Hon. CATHERINE CUSACK: It just seems to me that it is all treated holistically as one problem when, in fact, there are two completely different issues—one, trauma, impacting Aboriginal communities.

Mr FAULKNER: I think they are entrenched.

The Hon. CATHERINE CUSACK: Yes. Can I ask about the Getting on Track in Time—Got it! Program for Aboriginal communities. Are you familiar with that?

Mr FAULKNER: Yes.

The Hon. CATHERINE CUSACK: I understand that that has been renewed. It targets Aboriginal children, kindergarten to year 2, and their parents and carers.

Mr FAULKNER: Our program for Indigenous children has not started. It is a mainstream Got it program at the moment. There are a lot of young Aboriginal children who go through that program. The Aboriginal focus has not started for us in our area, but it is due to start.

The Hon. CATHERINE CUSACK: I want to ask about training. I understand that in the Hunter health area it is mandatory for all workers to have training in Aboriginal healthcare issues. Are you aware that that has been undertaken? Has that been effective?

Mr FAULKNER: Are you talking about cultural respect training that all health staff have to take? Is that the program?

The Hon. CATHERINE CUSACK: I am sorry, yes: mandatory cultural training for all New South Wales health staff to improve cultural safety.

Mr FAULKNER: Unfortunately, I do not think that is very good. Sorry.

The Hon. CATHERINE CUSACK: Thanks.

The CHAIR: It is good to know.

Mr MICHAEL JOHNSEN: That is what you need to say.

The Hon. GREG DONNELLY: Would you like to elucidate and explain why you think that.

Mr FAULKNER: There are a couple of things. One is that because it is mandatory people just go for the sake of going. So they do not really go with an open eye, thinking, "Okay, what can I learn? What can I embrace to become better?" So they already have barriers up before they attend. Some people just do not attend at all. To do it once during a 20-year working period, what do you really learn? If you do it once for two hours in a day you do not know much about Aboriginal culture. It is about wanting to join with an Aboriginal service or Aboriginal team. That is half the battle. It is what you learn when you are around Aboriginal people compared to learning in a classroom or in a room for one day. I just do not think it works. It is a lot of money to be spending and I do not think it is a lot of value.

Ms JODIE HARRISON: My question relates to the statement by Mr Faulkner regarding family support, and the fact there have been increased mental health and suicide issues amongst young people as a result of lack of support for families and increasing hospitalisations. Is there a difference for Indigenous people in support we need to provide families to non-Indigenous people and how different is it?

Mr FAULKNER: I can only speak of my own experience. When I first started this program 14 years ago in our system there was only two Aboriginal people coming. We now have over 1,000 young people coming through our system. We have an Aboriginal focus program and it is now working. We are seeing a lot of our

young people with mental illness and we are keeping them out of hospital, but it is an Aboriginal-focused program. Again it is not putting a Band-Aid over something and then want to remove it. We are focusing on this and working hard at this and improving that.

We have non-Aboriginal people that are interested in Aboriginal issues who are part of our team that also support us as a holistic approach. They are doing all the things that are important to Aboriginal communities and families, that is the difference. It is the same with the family support program. You have an Aboriginal worker in a mainstream setting, again it is tokenistic, realistically. If you have an Aboriginal team you have an Aboriginal team that really want to support Aboriginal families, because that is the battle that we have. If you see an Aboriginal face you will talk about your issues compared to having one Aboriginal face and a non-Aboriginal face around you. It does not work without having a holistic approach around everyone wants to be a part of that team.

Ms JODIE HARRISON: Could you provide detail on why it needs to be that level of Aboriginal focus? What is so different? What do we need? Why is there that difference regarding trauma? What is done in the Aboriginal program that is so different to the mainstream program?

Mr FAULKNER: We know the issues so we are going to be able to support them better than not knowing the issues and we know some of the things that are important and how you do and what family groups you need to go to and who is the person you need to make contact with compared to not making contact with. It is just that networking group you need to understand. And it is the roundabout way of narrative therapy for us is that we go from A to C and all the way to K and then you have to go to Z. That is your story, you have to pick that up and run with that and work that out. As an Aboriginal person I understand that, I know how to grab that and put that together and put it in the right order. So for a non-Aboriginal person it is very difficult, not all the time but sometimes, to understand that story. If we have Aboriginal teams and Aboriginal people around you and skilling Aboriginal people up to do that you are going to have more improvement in our issue. Does that make sense?

Ms MASTERS: I would like to add, a bit of flexibility around the program as well. I find with our young people that they do not turn up for one appointment, that is it, closed. It could be for a variety of reasons. I think having an Aboriginal-focused program there is more flexibility and understanding that it is not one strike and you are out, it is, "Okay, what happened there? How can we work around that? What are the barriers?" Providing an holistic approach with that ingrained flexibility to really support that person to access those services.

The CHAIR: I welcome Ms Manton.

Ms MANTON: Thank you.

The Hon. CATHERINE CUSACK: Ms Masters, without giving identifying details can you give an example that highlights what you are talking about?

Ms MASTERS: It might be a case that they have a counselling or psychologist appointment.

The Hon. CATHERINE CUSACK: A case example, if that is possible?

Ms MASTERS: 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 access to service back a significant amount. It might be a case, as a caseworker myself, we only have two caseworkers, if we cannot get them there on that day they might have to wait another month to access further support. It might be this young person needs regular fortnightly/weekly support and it was not always easy to get there. Just need the flexibility around regular access. Does that answer your question?

The Hon. CATHERINE CUSACK: Yes, it does.

Mr DAMIEN TUDEHOPE: My question is along similar lines. Can you give specific examples about cases where the system has failed and what was done wrong in relation to a specific case? Then turn your mind to a case where you say you have prevented a youth suicide and what went right?

Ms MASTERS: I am just trying to think of someone.

Mr FAULKNER: In 14 years I have had one loss unfortunately. Again 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. Does that answer your question?

Mr DAMIEN TUDEHOPE: What I think you are telling me is that the thing that works best is if there is family support around them?

Mr FAULKNER: If there is family support, yes.

Mr DAMIEN TUDEHOPE: Where there is no family support they are much more at risk?

Mr FAULKNER: Yes.

Mr DAMIEN TUDEHOPE: If you come across a young person who has very little family support, what do we need to do to replace that?

Mr FAULKNER: My experience would be—and I think I spoke about this earlier—the family support systems—having an Aboriginal team around him out in the community, not so much in the setting—would really support. My setting, for example, is not where it should be; it should be out in the community with support around that—helping them get a job, helping them get to school, helping find accommodation, helping with supporting his money options and working out a budget system. At 17, that is almost a man, so you are really starting to think about his future and where he should be heading off in a direction.

Mr DAMIEN TUDEHOPE: Do you say that that does not exist already?

Mr FAULKNER: Not for us, no.

Mr DAMIEN TUDEHOPE: Nothing at all in the Hunter?

Mr FAULKNER: Not an Aboriginal support service, no.

Ms MASTERS: Especially not in the Upper Hunter. Our services are really thin on the ground up here, particularly Aboriginal identified services. To have just another space from the community is really difficult to find, especially for these hard-to-engage young people. A lot of services, if they are difficult to engage, they say, "You just come back when you are ready" and they do not come back and they slip under the radar. Again, that comes back to having flexibility and just being patient, having compassion and empathy and really understanding that it is difficult for young people to engage with services, because they are terrified of the system. They are terrified of being removed or the cops rocking up and things like that. The services up here are all but non-existent. For Michael and I to have a holistic approach and have a team around them and to engage the community is really, really difficult.

The CHAIR: Ms Manton, how do the primary health networks, particularly in the Hunter, generally work with the local Aboriginal mental health services? Are there opportunities for further collaboration? What can be done to bring it all together?

Ms MANTON: From my experience of what I have seen, having been in the primary health network for a short amount of time—however, I have travelled the countryside in that short amount of time—there are not a great deal of Aboriginal specific services for people out there. There are mainstream services out there, but their engagement into the Aboriginal community needs a little bit more work in terms of partnership and collaboration. Part of my role is to ensure that that collaboration is happening and ensuring that the services that we do commission are culturally safe and appropriate, and they are engaging the Aboriginal community. My answer would be: Yes, we are looking at definitely the collaboration of the services that we have commissioned.

The Hon. GREG DONNELLY: How does traditional Aboriginal culture understand the notion of mental health problems? Does Indigenous culture have a conception of what mental health is? We are dealing with Indigenous culture in 2017 in New South Wales, and my question links into the attitude of elders and their understanding of mental health as an issue in Indigenous communities. How do Indigenous communities comprehend mental health problems? Do these communities have a particular perspective or are they dealing with what exists without bringing a perspective to mental health issues?

Ms MANTON: Are you talking in terms of spiritual side?

The Hon. GREG DONNELLY: Potentially. Forgive my ignorance, but I do not know whether mental health issues—anxiety, depression—manifested in young people in a traditional cultural setting going back a long time. These issues do manifest themselves in young people now, and I am wondering how the communities are coming to terms with a traditional view about mental health issues compared with what they are trying to deal with now. Obviously, there are some serious problems amongst the youth. Can anything from traditional culture be imported to assist in dealing with these issues?

Ms MANTON: That is a very big question. I can answer maybe a little bit of it, not a great deal of it. The thing that any mental health facility could take into consideration is some of the spiritual factors that exist within Aboriginal communities. That can be from a range of things, from visits from police and that type of stuff. If you think about mental health, it really did not exist pre-1788—let us be honest and real about it—when kids were being removed and put into other hands. It is very complicated for me to answer this question. For you to really think about this stuff, you have to have an understanding of pre-colonisation and the family structures and the learnings that existed, as well as the spiritual sense that not all of us are accustomed to now. A lot of us are still trying to find our way in that spiritual sense. I do not know if I have answered that question, and I probably cannot answer that question, but in saying that mainstream services do not really—from my past experience of working in that sector—understand that concept. I do not know if I made sense and I probably did not because you are looking at me blankly. It is a very complicated question, and I cannot really answer it.

The Hon. GREG DONNELLY: I was thinking about young males, for example, who in the traditional Aboriginal community would go through a period of being inducted into manhood by the older males in the mob, the community, the tribe. That took place over a period of time, and they went through a range of steps or a process as part of their induction into manhood to give them their identity of being an Indigenous man. It gave them standing in the community and all the things that came with being an Aboriginal man. I suspect that that does not happen so much these days.

Mr FAULKNER: No, you are correct.

The Hon. GREG DONNELLY: I wonder whether there is scope to bring forward those sorts of things, which are intrinsic to what it means to be an Aboriginal man. Obviously it is important to them that they are Indigenous and perhaps we should look at how they can rediscover it, although perhaps not the full process, which took place over a period of years from the age of 11 to their late teens. Perhaps we could look at the steps that taught them about being an Aboriginal man and about being proud to be an Aboriginal man.

Mr FAULKNER: From my experience working with young people I have thought about colonisation because we were near one of the early colonies. For us, colonisation meant that we lost a fair bit of our back culture, and the sense that sometimes the law and things are important. There are some who still have it and still teach it, and that is great. I think what system we are grabbing now is that we are grabbing our jail system. We have a few young guys that have said they have to go to jail to become a man, because that is what their dad and their grandfather have done. They are grabbing that system and making it their system now to prove that they are a man. They think that once they become 17 or 18 they go into the big house and, "Once I have done big house time that means I am now becoming a man."

They are the kids I have had to work with at the back end of when they are 17 and 18, before they have moved on to the adult system. I try to talk to them and get them to think about whether that is a system they want to be a part of. "Are there not other things we need to think about? What about your other uncles over here, who have not done that? Why do you have to follow your dad compared to your uncle?" Trying to think about that for them is quite difficult, because they are focusing on, "That is what my dad did." A lot of them could not understand or could not grasp that, but that was a system I had to work hard at, trying to change a few of the young people's thinking around going to jail to become a man.

The Hon. GREG DONNELLY: That same sort of attitude is in the white man's culture as well.

Mr FAULKNER: Possibly.

The Hon. GREG DONNELLY: Well, not possibly—it is. Young males who do not have strong male figures in their life from an early age often drift. We see that with a lot of young white males ending up in Juvenile Justice and working their way through to the adult prison system.

The Hon. PAUL GREEN: You talk about the lack of resources in the Upper Hunter particularly. How do you work together in a collaborative way to perhaps cover each others' bases if there is a lack of resources and you have some resources?

Ms MASTERS: Flexibility and just building relationships.

Ms LAYER: I think from Ungooroo as a community organisation it is multifaceted. What we are seeing is the different programs. We have a general practice and then we have got programs with the Specialist Homelessness Services [SHS] under Family and Community Services, we have got the youth workers and then we have got programs around employment and business development. We have also got a dental program. This is a case scenario: a young boy come out of Baxter, did not want to go back there, wanted to really work on some life skills, so he was seeing the youth workers. He had no teeth so we organised to go and get some oral health care. He came and saw the GP, identified that, and then he went. There were some issues around mental health, but they were able to work through that with a bit of counselling.

Because of the employment officer there, it was a good synergy and he moved into that process and then got a part-time job bricklaying—some casual work—and it gave him a sense of identity to move forward. We have found those sorts of synergies between all of the different programs and the referral processes happening internally are capturing and creating pathways for these kids that are really positive ones. It is interesting—you will come out and see the GP talking to the youth workers about a particular case and it is all moving forward. We have found that working really well, particularly of late.

The CHAIR: Thank you so much for appearing before the Committee today. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

Ms LAYER: Yes.

(The witnesses withdrew)

JAELEA SKEHAN, Director, Everymind, affirmed and examined

MARC BRYANT, Program Manager, Suicide, Everymind, sworn and examined

DANIELLE ADAMS, Service Manager, The Way Back Support 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

The CHAIR: I now welcome representatives from Everymind, LifeSpan Newcastle, The Way Back Support Service, Hunter Primary Care and the Hunter New England Central Coast Primary Health Network. Thank you all for appearing before the Committee on Children and Young People today to give evidence. I confirm that you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses. Would any of you like to make a brief opening statement before we commence with questions?

Ms SKEHAN: I am happy to make a brief opening statement, if I could, just to put a couple of things on the record. We provided a written submission to the Committee under the Hunter Institute of Mental Health, but as of 9 October we renamed to Everymind, so we are giving evidence today as Everymind. Also, Everymind hosts the two LifeSpan Newcastle coordinators, so if there are any questions today in relation to LifeSpan Newcastle, I can address those. None of the coordinators are specifically giving evidence but I am the senior leader that works on that particular area.

I also want to note a couple of things. Our role at Everymind spans local, State and national work in suicide prevention. Often when we are called to give evidence, it may be around how those differing ways in which we work might interface at a local level or at a State level. We have suicide prevention funding that is funded by the Commonwealth Government and rolled out across all States and Territories, and funding from philanthropics as well. We do not have any current projects that are funded by the State Government in relation to suicide prevention but we have a role in suicide prevention across New South Wales and a number of initiatives which are running locally in the Newcastle or Hunter region.

I want to make a very brief comment up-front about data and the issue around youth suicide more broadly. In one respect I think often the community gets a little confused around where the impacts of youth suicide may lie in terms of data and others. We know that while it is a major issue for communities and for families that are affected, young people actually have the lowest rate of suicide compared to other age groups in Australia. We know that men over 85 have the highest rates of suicide, followed by men in their thirties, forties and fifties, and young people have the lowest rate of suicide. That is not to say that it is not an issue.

The other data to take into mind is also that suicide is a leading cause of death for young people, which practically means that if a young person is impacted by the death of another young person, it is more than likely that that death has been a suicide. Those two bits of data play out in slightly different ways. It is important for people to understand that there are other age groups that have higher rates of suicide; we also know that young people can be particularly impacted by the suicide death of peers, given that young people are less likely to die by other means.

The third thing to say in relation to data would be that, while we do not have good data around suicide attempts or even self-injurious behaviour that may or may not be associated with suicidal behaviour, that tends to be higher in younger people than perhaps older people—at least the data that we have indicates that. So we tend to have a higher proportion of young people making suicide attempts or injurious behaviour that then is a lifelong risk factor for suicide. It is important for us to understand the different things that data tell us about the risk of suicide and also the impact of suicide on young people. I think the earlier we start the better. I have a few issues that I can raise as part of the questions that I think hit some of the particular terms of reference of the Committee.

The CHAIR: Does anyone else wish to make an opening statement?

Ms ADAMS: I would just like to send apologies from Katrina Delamothe, the Mental Health Executive for Hunter Primary Care, who is unwell today.

The CHAIR: Thank you so much. Members are asking about Everymind. Could you give a brief outline of what it is?

Ms SKEHAN: Everymind is actually attached to the Hunter New England Local Health District in governance but we have a remit to work nationally in the prevention of mental illness and the prevention of

suicide. We have existed for 25 years this year so we are celebrating our 25 years of service. Our remit has been to work nationally in the prevention of mental illness and the prevention of suicide since 1997. We are particularly well-known for running national and other programs of communication around suicide. Mr Bryant and my team lead the Mindframe National Media Initiative, which is working nationally on the reporting and portrayal of suicide and mental illness by the media.

Also, we have community resources around how we talk about suicide. We have also been involved in innovation around family support programs for those impacted by suicide and suicide attempt. We have an active role in the first LifeSpan trial site in Newcastle and also support for the Way Back Support Service, which is the biggest trial of an after-care service funded by Beyond Blue rolling out in Newcastle. Does that provide enough context?

Mr DAMIEN TUDEHOPE: One of the more difficult components of youth suicide is often referred to as contagion. Would you like to give us a snapshot of how you see that as an issue and how you deal with it?

Ms SKEHAN: I am happy to start and others may follow. We know that contagion or copycat suicide—there are a range of different terms that might be used for the same thing—or imitation suicide, can occur when people become exposed to the death of others or we have groups of people who are connected in suicide either by place or some other connection. We have worked in this space a little bit because of our role nationally with the media so we have been working or almost 20 years on reporting and portrayal of suicide because we know that media portrayal is just one method by which people hear about or become exposed to the details of someone else's death but we also know that it happens around communities, family connections and others. So media is only one method by which contagion can occur. Generally if we think about contagion by media, it is more likely to occur where that coverage is prominent, where it is repeated and where there are specific details around methods used, locations used or where a death is glamorised in some way.

Mr DAMIEN TUDEHOPE: Would you make some recommendations in relation to that?

Ms SKEHAN: Yes, I think what we might call postvention support or supporting communities or families that have been impacted by contagion remains one of our critical areas of focus nationally. We know the national Standby Response Service is funded nationally to do that and headspace School Support, if a death occurs within a school. Our team does provide support at the community level. As to how we manage media, usually we work in partnership, whether it is the primary health network or the local health district that might have control of the situation or is managing how people communicate with each other and externally around those issues and support the agencies on the ground around how communication occurs.

One of the things that is really important is for regional areas and communities to have a plan in place about how they are going to respond if and when a death occurs, particularly if one death is then associated with perhaps even a second death. Often what we say and international best practice is that if a community believes there is contagion or a community is concerned, usually that would be enough to trigger a response, whether statistically that has been quantified at that stage or not.

Mr DAMIEN TUDEHOPE: What does that response look like?

Ms SKEHAN: That response needs to look like making sure that we have someone who is managing the multilevel response that might be required; someone within the local community who is responsible for coordinating activities across the board. We need to identify people who might get our communications in order—primary health networks, local health districts, major non-government organisation partners which are in that region, including education if it is involved and others, plus national partners that might be able to support action at the local level but coordination of that is really key.

Where we have seen responses slower to emerge may have been where people have not had a plan in place of who would lead, if there was not a concern around contagion. We need to ensure that we understand who else may be at risk following the death of, say, one, two, three or more young people, as may be the case for this particular hearing and how those people might be best supported, using available services in the local area or external services and how we communicate more broadly. In the past I have seen media throw fuel to a flame in a particular area where people are concerned about impacts on other young people where there have been deaths and then the escalation of communication across social media or media can actually heighten those impacts somewhat.

Mr DAMIEN TUDEHOPE: Does anyone else want to make a comment?

Ms ADAMS: I would just like to add that headspace has a school support program and will be able to speak a little more on this. Some anecdotal feedback we have had from recent events is that often it is not narrowed to one school. People from multiple schools will be affected or the young people are no longer at

school. There needs to be some flexibility about being able to communicate with sporting clubs or other non-health organisations. If there is a plan in place, it is getting out to those agencies because there have been some youth who are not at school and have felt quite affected by what has happened but do not have a place where they can go. Linking in with, not necessarily health agencies but some of the social agencies could be beneficial.

Mr MICHAEL JOHNSEN: I will ask this as an open question to everyone here. You said your organisation has been around for 25 years. Headspace began in that time. I think it is probably fair to say that support services have grown over at least the last two decades. Part of your remit, for example, is prevention. Why do we have all these support services that also focus on prevention yet at the same time we are seeing a relative skyrocketing of numbers of people engaging in self-harm and eventually suicide? What is going wrong?

Ms SKEHAN: That is a challenging question to answer. In the first instance as to taking a longer term view of this is that our rates of suicide, particularly young suicide, hit their peak in the late 1990s, so 1997 and 1998 we had our highest rates of suicide. What we have actually had was a 10-year decrease in suicide rates, particularly in young people, so we have seen a dramatic drop in suicide rates among young people, both in the cohort under 19 and the cohort between 19 and 24. But then we have actually had a few years where we have seen some slight increases again until the most recent data we have had. I think in the late 1990s we actually had a National Youth Suicide Strategy, particularly because our rates of suicide tended to be higher in young males so we had a concerted effort at the national level and at the State and local levels around suicide prevention in this country.

For want of a better word, perhaps we got a little bit complacent in some of those middle years. We had not had a refresh since about 2000 or so in our national suicide prevention strategy. Having said that, a number of countries around the world have actually seen really dramatic increases in suicide rates in the five or 10 years previous that we have not seen here in Australia, which may or may not indicate some things—I share with you that I have lost family members to suicide so I share with you what I hear is your concern around suicide. All of us who work in suicide prevention and in the community more broadly are very concerned. There have been some reductions in that time. I think the current challenges for us are around how we make the best of the opportunity of national and state-wide reform and how that operationalises itself locally for communities. Sometimes there can be a disconnect between things that we roll out nationally and state-wide and how they come together meaningfully for people on the ground, whether they are currently experiencing a number of deaths or trying to coordinate and to manage a whole range of risks.

We have also had much more focused attention on crisis response rather than having a long-term vision for prevention. As an organisation that is committed to prevention, the issue can sometimes be the hard slog to get government funding when government terms in office are a lot shorter than the investment timeframe we need to look at for prevention approaches. We are really looking at the work we do in the early years and with children before they hit the age of 12 and how we can respond to the sorts of risks, challenges and opportunities that those childhood years provide us with. We try to ensure that we have young people, adults, and older adults who are healthy and well-connected, and that we have service systems involving people who are well trained, well connected to each other and also well supported to ensure that we can make a long-term difference to this issue and not have piecemeal approaches.

The Hon. PAUL GREEN: You say there are countries that have experienced increases and that we have experienced decreases. What are we doing differently and has someone measured what those differences? Is it intervention with school programs?

Ms SKEHAN: That is a good question and it is not one easily answered. Our investment in research around suicide prevention has been lower than our investment 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.

I think there have been some great advances here in Australia around e-mental health. We are ahead of the game internationally in our e-mental health approaches. We most certainly were one of the countries that had a huge investment in school mental health in the late 1990s. When it started, we were ahead of the game internationally, and I know there has been a refresh around that nation-wide approach. The World Health Organization noted our Mindframe program as being international best practice. Some of the programs funded in the late 1990s and early 2000s got some traction and showed national leadership. However, we must also ensure that we continue to adapt to the evidence and to what communities and our populations need.

Ms ADAMS: There is some research around the community benefit of a suite of interventions. LifeSpan is currently looking at multiple interventions from the individual to the community. There is modelling happening around what delivers the biggest impact for the dollar. At the moment, some of that evidence supports aftercare services following suicide attempts, general practitioner training and psychosocial intervention.

Ms JODIE HARRISON: I refer to the issue of contagion. I am particularly interested in the role of social media, and the good and bad impacts. How do you deal with social media in terms of contagion? I know that Ms Skehan has a view on shows like *13 Reasons Why*. How do we manage that sort of thing? I am not talking about place-based contagion.

Ms SKEHAN: I will answer first and then pass to Marc Bryant, whose team works in this area every day. It is important for us to note that the nature of contagion has shifted. Our research originally looked at close family and friends as being critical in providing support following a death. We know that particularly with young people those ripples can go far and wide. 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.

The evidence base we are working with on social media is a lot smaller than the traditional media base because its speed has been greater than the speed of our traditional research. We are working with some challenges, not to mention some great opportunities, in working with partners in the digital area. There is a strong commitment to youth mental health in this country, and we can tap into that opportunity. Marc Bryant might be better placed to respond because his team is working directly with providers like Netflix and thinking about social media.

Mr BRYANT: There are two areas with social media. There are prevention opportunities and a range of services and campaigns to use social media to maximise reach for behavioural change. There are the tools that Facebook and Twitter have developed themselves for people in distress; there ways that people can react to and report those kinds of things. An online mechanism will obviously have some impact in terms of prevention. In respect of contagion, there are obviously conversations that will happen in those youth spaces. There is an opportunity for agencies to see what conversations are happening. There are also ways that they can equip themselves to achieve good interventions and messaging to help people seeking information and support tools and to monitor of type of pain or grief those communities are feeling.

We believe that traditional media still plays a critical role. People in those online spaces are sharing media stories. People are not drafting 300-word monologues for everyone to a share; they tend to send brief messages and to share news reports. We saw that with a TV broadcast containing not explicit but certain information that was not helpful to a community that was going through tremendous psychological distress. The show does not traditionally attract a youth demographic—it usually has a different audience—but the content has been shared by thousands of young people because it referred to a particular individual who had died.

Mr DAMIEN TUDEHOPE: What was the show?

Mr BRYANT: It was an ABC program that was shared locally. That is one of the issues we had.

Mr DAMIEN TUDEHOPE: What was the show?

Mr BRYANT: It was the *7.30 Report*.

Mr DAMIEN TUDEHOPE: About what?

Mr BRYANT: The episode was about Grafton and the suicides there. It focused on a young person and named them. The local agencies were not aware the show was going to be broadcast, and there was no-one with a good insight into what was happening to provide perspective. It is about not having the right experts on TV shows. We work closely with the ABC and provide some critical feedback. We are invariably looking at its policies. Mark Maley is in charge of editorials. When they know a show talks about a number of youth suicides, they will go through particular procedures to ensure they talk to Mindframe or the suicide prevention coordinators on the ground to check that they are talking to the right people. In the past, the journalist would talk to a few people and that could include family members, who do not know how to talk to the media about suicide.

Mr DAMIEN TUDEHOPE: Do you have a specific example of someone who watched that program, posted it on social media and then had an adverse response?

Mr BRYANT: Obviously there has not been any evidence; this is more anecdotal evidence from the ground. Yes, it was seen by young people and there was an adverse impact. But I am not privy—

The Hon. CATHERINE CUSACK: How do you know it was adverse? That is what the Committee is trying to understand.

Mr BRYANT: There were presentations to services and someone also died within three days of that program being shown. We cannot say that was a result of the program, but that is the sort of impact I am talking about. That is the kind of impact you can have in communities.

Ms SKEHAN: I think it is an example of where you have community concern and people scrambling. While media can play a positive role in suicide and suicide prevention at times, it can also throw fuel on a fire. Generally, demographics would say that young people would not be watching programs like *7:30*, but the advent of social media and also community concern—where young people are talking to each other about this issue a lot, particularly if the media are covering it—just escalates the issue on the ground. All of that plays together.

Mr BRYANT: One of the things that we are looking at as solutions for the future, working with Grafton and other primary health networks—all those suicide prevention collaborations, particularly the trial sites around the country—is that Mindframe will help support them to have good media protocols for those communities to make sure that the community understands the impact or the potential adverse reactions when handling the media can go wrong. So we get them to try to think how they might coordinate those responses. So if someone in the community wants to do a TV interview they let other agencies know, and that kind of thing.

The Hon. CATHERINE CUSACK: I really want to follow this up. The role of the media leading to contagion is a very difficult issue. I am from the North Coast. I am quite familiar with the Grafton situation. It just did not seem to make any difference whether there was a blackout or not, with respect to the number of kids—as has occurred here in this region. There have been so many suicides, tragically. How do you know what the role of the media is, and whether talking about it is a bad or a good thing, or whether there is a way you can talk about it? Can you give us some direction on that, because it is a very deep and difficult issue for us to understand? Some people say not talking about it makes it worse or not talking about it makes it better. How do we know?

The CHAIR: We have been dealing with the issue of just holding the committee hearings.

Mr BRYANT: I guess the community should know how the community is feeling at the time when we have those more public conversations—whether they are in a public room or during mass communications. That is why having good communications strategies in local communities, and having those right prevent conversations—

The Hon. CATHERINE CUSACK: Can I ask it differently, perhaps? What research can we draw upon to inform good communication strategy?

Mr BRYANT: That is falling on Mindframe. We do give the right strategies and tools for messages that are helpful and to develop them locally—

The Hon. CATHERINE CUSACK: I am sorry to keep interrupting, but what is the research—the empirical basis—on which this advice is being given?

Ms SKEHAN: Can I answer that question? There are more than 100 international research studies which have shown the association between media reporting and suicide deaths, and the association of increased rates of suicidal behaviour—whether that is attempts or deaths—following. One of the challenges in Australia is our population size, which is relatively small. Having said that, it is internationally accepted that the body of evidence around media portrayal of suicide deaths and the associated risks with that is held. How that plays out, though, on an individual level, is that none of these issues is black and white. So, very rarely would our team, which leads Mindframe, be encouraging any kind of media blackout unless there was evidence from the local community that there was concern. So media can and do report suicide more than they ever have in Australia.

The Hon. CATHERINE CUSACK: Can you tell us which of the studies can give us a bit more guidance on why this is the case, and the nuancing of it between key groups.

Ms SKEHAN: Yes.

The Hon. CATHERINE CUSACK: If you want to take that on notice that is fine.

Ms SKEHAN: We can. There is a review on our website which we can send you. It is a review of all the international evidence, which was done by Jane Pirkis at the University of Melbourne—and an updated

review of all that evidence for fictional portrayals and non-fictional portrayals is currently in progress. We have commissioned that, externally, to a leading researcher in Australia in that area. The current review is on the Mindframe website. We can send a link to you, which summarises where the evidence is at, and what it says. The new review of that evidence is currently being done. We make sure that we are capturing all the new and available evidence.

What we do know is that there is some emerging evidence around the sorts of media messaging that might be protective—and also in communication, which is around messages of hope, that focus on people who have lived experience of suicide and can talk about the things that worked. It talks about mastery. All of our recommendations to local, national and other agencies are based upon translation of that evidence as it emerges. But Jane Pirkis and her team are doing an updated review, which will be soon available.

The Hon. CATHERINE CUSACK: Based on that, can you help us to know how we can have a community conversation about youth suicide, when the usual avenues appear to be blocked?

Ms SKEHAN: In some respects my response to that would be that I do not believe that all of the usual avenues are as blocked as they may seem. We have evidence from a media monitoring study in Australia that since the guidelines existed in Australia—they are more than guidelines; they are training, support and ongoing support around this work—there is more reporting of suicide now than there was before they existed. We have other tools—community tools—about talking about suicide, which are available under the Conversations Matter website, which was funded in New South Wales originally. What Mark was referring to was that we are referring to primary health networks with other lead mental health and suicide prevention agencies to ensure that people have the tools to be able to communicate about suicide in their local communities and nationally.

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. For example, we have heard in the past from a number of communities that talking about how preventable suicide is when communities are grieving may not be the appropriate message for that time, but one for us to come back to—how do we make sure that grief and support is at the frontline of our messaging around that time?

The Hon. GREG DONNELLY: I do not want you to take offence at this question but I will couch it in these terms. We have just heard evidence from Mr Faulkner, Ms Layer, Ms Masters and Ms Manton, who were dealing with Indigenous matters in mental health and suicide. They have all gone; they have left the room. In fact, they had left the room before you had even settled at the desk. It just bowled me over. I thought that some of them may have stayed back. Am I reading something into that—that there is a complete disconnect between the work that they are doing in the Indigenous community and yourselves such that they would not even bother to stay back and listen? I am not passing judgment on them or yourselves. It is just a stark observation that I have made.

Ms SKEHAN: I would say, without any other evidence, probably not. Many of us, including myself, had scheduled the time in which we were asked to come to the hearing today. So I did not arrive for their part of the hearing either, because I was not aware that they were presenting beforehand. So I could probably say the same thing for us. We did not come early enough to listen to them. I think there are issues that are particularly important for our Indigenous agencies and services to drive forward. I do know all of the people who were on the panel earlier, and have either sat alongside them or worked with them in our local region in the past. So, without speaking with them, I would not take anything from that.

The Hon. GREG DONNELLY: It was a bit of a provocative question, but it struck me. It does not reflect on any of you individually but it just struck me. What they spoke about—I am sure you have heard them speak about it before, either individually or collectively—was, as they see it, a need for a team, group or collective approach to address mental health issues amongst Indigenous young people. I am just wondering whether—once again I am not trying to be provocative—at the professionally trained level, which would include yourselves, you would have the same view as those previous witnesses. Or do you partly agree with that proposition or not agree with that proposition? To the extent that there is a disconnect—if there is such a disconnect; I am not stating that there is; I am wondering about it—what are your thoughts about that?

We have the hard trained edge—the people with medical degrees and trained people who work inside the formal New South Wales health system—and then the people like the Indigenous community working at the margin of things, if I can describe it that way, trying to deal with issues within their communities. Is there more that we can be doing or considering doing to try and make that linkage—that connection—better and stronger?

Ms ADAMS: I can answer in terms of our service, just a small piece. There is an issue around distrust of services and government and health organisations and we all fit into that. With Indigenous people there is a

lot work to be done. In our service we recently looked at Aboriginal referrals into our service and how they engage with our service compared to our overall rate of engagement with clients. What we are finding is when we are able to engage with Indigenous clients it looks very similar in terms of them staying with our service and connecting, but where the difference is is getting in contact with the people initially. That could be mistrust of who we are.

Mr DAMIEN TUDEHOPE: They were indicating that part of the problem was that institutional healthcare was an impediment to Indigenous healthcare, do you agree with that?

Ms ADAMS: When we undergo cultural competency training that is one of the things that is emphasised, that is still embedded.

Mr DAMIEN TUDEHOPE: So, how do we fix it?

Ms ADAMS: I do not have the answer. The message from the Aboriginal community is talking to them and not imposing an answer. I think us sitting here and trying to solve that is not the right space.

Mr DAMIEN TUDEHOPE: What do you think?

Ms EVERTON: The Primary Health Network has started a program in the New England area called We-Yarn, where one of our providers is contracted to go into the Indigenous communities and bring the community together to talk about suicide prevention and mental health first aid, but it is about that engagement. We can also put them in contact with services that they may need through that community group. That is what we are doing in the New England area. We have also developed—in the Newcastle, Central Coast, Hunter area—community action groups as well. That is not just Aboriginal focused, but we try to have an Aboriginal representative in that group. That is all about suicide prevention and putting people in touch with the appropriate services. It is all about community engagement as well. Up in the New England area, because there is a higher Indigenous population, we have specific Aboriginal groups up there.

Ms ADAMS: Our Aboriginal advisory group are talking to us about their ideal which would be to have an identified Aboriginal support coordinator in our service and we are trying to get funding for that.

The Hon. GREG DONNELLY: Please do not misunderstand, I am not having a go at you, I am trying to tease this out further.

Ms SKEHAN: Do you mind if I just clarify one thing? The people sitting here before and one of my colleagues that I saw leave have just as much professional qualifications as I do. I think there are many Aboriginal people working inside the system with formal and extensive qualifications and not just working in a community way. Getting a combination of both and that communities drive solutions for communities, where we are talking about Aboriginal and Torres Strait Islander issues. And ensuring that our organisations have a commitment to having professionals inside of our organisations who are Aboriginal and Torres Strait Islander at the national, State and local level.

The Hon. GREG DONNELLY: Can I just make the point, and not being disrespectful, if we are dealing with mental health issues and we get to the point where individuals who do need to be placed under fulltime care because of the potential for them to suicide. Clearly people with medical training are critical in being able to make those evaluations to ensure those people do not find themselves in harm's way and are, in fact, placed in a setting where they cannot harm themselves. Surely that is the case. To the extent there may not be those people with medical training, and I do not mean social welfare training, I mean medical training to be able to make those judgements, there may be a gap there which is leading to this increase in the rate of suicide of Indigenous people, which is what we understand is the case up here in the Hunter/New England. Or, am I barking up the wrong tree?

Ms SKEHAN: I feel that since there are no Aboriginal or Torres Strait Islander people sitting on the panel, it feels difficult to answer that question.

The Hon. CATHERINE CUSACK: In relation to the contractor you said has gone into the New England, which community was that?

Ms EVERTON: Good SPACE is the contractor from the Primary Health Network and they are going into multiple communities. They are going into Moree, Narrabri, Armidale, Tamworth and Glen Innes. It is all over New England, it is not just one specific community, it is all over the New England area conducting the We-Yarn workshops.

The Hon. CATHERINE CUSACK: And what is the outcome you are seeking from the workshops?

Ms EVERTON: It is about community engagement. We do ask that the community, when we go in to do the We-Yarn workshops if they would like to be evaluated and if they would be willing to do that. Not all of them are willing to participate in the evaluation so we do not have an accurate measurement of what the effectiveness has been. We have had a report sent through over the weekend. I have not had a chance to read that yet. There were three communities willing to be evaluated in that. I have not had a chance to look at that yet and see what the outcomes have been. It is more being focused on community engagement. If there has been a youth suicide or an adult suicide in that area it is about bringing the community together to talk about it. What can they do in the community? How can they make things better? What are the issues that those people have been facing? Making sure that people who knew that person are well supported and in touch with the appropriate services if they feel they need them. It is really about local community engagement and making sure that the communities are well supported in those areas.

The Hon. CATHERINE CUSACK: I have visited those communities many times for many different consultations including drug and alcohol, juvenile justice and youth crime rates. At the end of the day it is a couple of families in each community, everybody knows who the families are. The kids with the drug and alcohol and the domestic violence problems tend to be the kids with the suicide problems. We are talking about multiple symptoms. My question is, given the tear in the fabric of those Aboriginal communities, particularly a totally displaced community—I know Bourke is not in your area, but that is a different situation there—why cannot we as a government work holistically on the people rather than the fragmented program approach where we have 20 different consultations in silos around portfolios all to deal with three people's problems in a remote community and we are using contractors to do it?

Ms EVERTON: Yes.

The Hon. CATHERINE CUSACK: Is it the best investment we could be making in resolving these issues?

Ms EVERTON: I think it does help to have community engagement because at the end of the day we have to get down into the grass roots with the people living in that community. We have to make sure they are engaged and we have to make sure they have access to appropriate services they may not otherwise know about. It is helping to have those community engagements. That is all I can say.

The Hon. CATHERINE CUSACK: Can I put it differently: my feedback is consultation fatigue, to be perfectly honest. Where the same thing is repeated over and over again, it is just a different name on the problem. Then we hear evidence of an unidentified case of a boy whose big issue is he has to get down the road to Muswellbrook and he has no transport to get down there. We can consult this community until the cows come home but if that boy cannot access transport to get to the counsellor in Muswellbrook what have we done to assist him?

Ms EVERTON: That is a valid point. I do think there is sometimes consultation fatigue, I do admit that. It has been not so much feedback from the New England area. The feedback is quite good, that they have really enjoyed that consultation and that community engagement. But I think it does help the Indigenous community to have them pulled together to liaise. The feedback I get from being up in the New England area—I up there quite a bit as well—is the lack of services in those rural and remote areas means they just do not have effective services. One of the things that I have been implementing and starting to roll out in the New England area is Advanced Suicide Prevention Training for GPs and practice nurses. They are all undergoing that training in the New England area, but it is voluntary, so they do not have to participate. Then I am putting screening devices into the practices to screen for suicidal ideation, depression, anxiety and risky drinking. That generates a report to the GP to tell the GP that this person needs X, Y or Z treatment. That might be e-therapy tools, which is where as a PHN we are really pushing e-therapy resources to people who have access to—

The Hon. CATHERINE CUSACK: Can you talk us through e-therapy, because that seems really important?

Ms EVERTON: 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, 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 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.

The Hon. CATHERINE CUSACK: Where do the e-therapy tools come from?

Ms EVERTON: They are coming from different universities. They are coming from Black Dog. Some of them are Australian government run, like MindSpot Clinic, which is run through the Australian government and myCompass is Black Dog. There are different sorts and there is a whole wealth of apps and

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.

The Hon. CATHERINE CUSACK: Can you point us towards some that target youth?

Ms EVERTON: Yes, moodgym is a youth one and myCompass is all ages. There are lots of different ones for different age groups, and those are the two off the top of my head that I know of for youth. The GPs have access to what apps go best with the person and who they would suit more than others.

The Hon. CATHERINE CUSACK: Half the GPs cannot use apps themselves. Is that not a bit of an issue?

Ms EVERTON: The main thing is having the GPs trained to feel confident with the apps and how they work, as well as what ones would suit different people. That is something that I have rolled out in the New England area.

The Hon. GREG DONNELLY: If today we were able to take a snapshot of the way in which New South Wales provides resources and services, formally through NSW Health as well as through the funding of NGOs, to tackle youth mental health matters in the Hunter and the New England areas, would everything be captured? Is there somewhere that accurately captures those resources, or are some services offered—either formally or informally—which are not captured? Knowing what resources are available is critically important to evaluate what is on offer. Is there an organisational chart, almost, that captures all of the resources?

Ms SKEHAN: The answer is yes and no, because at the moment we are in the grips of some changes. As I said, those changes give us some great opportunities, but they also pose some potential risks if, at the community level, we do not link them up. With the Commonwealth shift to regionally commissioned services around suicide prevention to the primary health networks, there is a national program that the Commonwealth funds plus there are some that the primary health networks in New South Wales are funding. There are also things that should sit in the Ministry of Health's portfolio around suicide and suicide prevention plus there always will be a range of NGOs providing services, or people through philanthropic funds or community group starting their own networks and work.

There are a range of processes we have in terms of capturing some of those. On a regional level, a lot of the mapping of services is being done through the primary health networks as one of the deliverables, and many of them have progressed through mapping and service planning. I sit on the NSW Suicide Prevention Advisory Group, which sits between the Ministry of Health and the Mental Health Commission of NSW and is currently looking at how we can develop a statewide framework to ensure that at a regional level we can join up what is a State responsibility and what are Commonwealth responsibilities commissioned through the primary health networks.

With nearly 20 years of working in suicide prevention, I probably could not take that snapshot and pick up everything. 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 do have mechanism at least to understand what is being commissioned through primary health networks, what is in the Commonwealth's funding and what might be getting up through the States, through the Ministry of Health and the Mental Health Commission. We will be tasked with developing a new suicide prevention portal, which is funded nationally, to try to capture some of that 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.

The Hon. PAUL GREEN: You say other nations have a gap compared to ours. Is it a positive that we offer students access to the Federal chaplaincy program and have people on deck at schools as part of the support of kids at school?

Ms SKEHAN: We have a number of years of experience of working in educational environments, and the jury is out on whether the chaplaincy program specifically is addressing those needs or whether they could be addressed in a different way. We know that for some young people having those services attached to chaplaincy may be prohibitive to getting support. I think that it is important that the Department of Education and other educational 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 New South Wales.

I know the Department of Education have done a range of things. They are looking at the statewide rollout of Youth Aware of Mental Health, which is a good evidence-based program for suicide prevention in secondary schools and is linked to one of the LifeSpan strategies. There is the National Mental Health and Suicide Prevention Plan in schools program, funded by the Commonwealth, which beyondblue is the lead on with headspace and Early Childhood Australia. They will be looking at a refresh of that approach. One thing the Committee should consider—and I say this now because I am not sure I will get another opportunity to do so—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. We have a strategy that is at least looking at the early years through to secondary school, but there are obviously more things that can be done in the ways in which our youth services, clinical or otherwise, interface with schools. But there is a gap.

The Hon. PAUL GREEN: I know there are a lot of services, but my point was that chaplaincy program is part of the solution and it is helpful that we have these services on deck in schools.

Ms SKEHAN: Having someone with a responsibility for mental health and suicide prevention in the school environment is really important, regardless of where that position might sit.

The Hon. PAUL GREEN: My point is more specific. I understand the double roles. We have student wellbeing people in there as well—I understand that—but it is more specific. I make a quick comment: I was at a Red Frogs thing on Thursday and your comments there are really true—that people finish the HSC, their expectations are not met, their relationship breaks up, they are hitting the grog and suddenly they have suicide ideation. They have been doing amazing things up there with the mental health camp.

Ms JODIE HARRISON: I understand that The Way Back Support Service is for over 18s.

Ms ADAMS: No, that is incorrect.

Ms JODIE HARRISON: Excellent. Is everybody who has been hospitalised after a suicide attempt offered The Way Back? I personally know of people who have been through the system—around November last year—and I am not aware of them being offered that.

Ms ADAMS: We are currently a trial initiative that is undergoing an evaluation. As part of that evaluation we are working specifically with the toxicology department at Calvary Mater Newcastle. Our referral criteria currently is purely through people presenting to the emergency department at the Calvary Mater, seen by the clinical toxicologist. All intentional, deliberate self-poisonings coming through the Mater are seen by toxicology. We offer the service to all people who present following a deliberate self-poisoning and who are assessed by the toxicologist.

The exception is they must reside within the Hunter-New England area as defined by the NSW Health boundaries. And some people have been excluded due to risk of harm to others—their dangerousness. If they have been violent or aggressive towards staff, that is a clinical decision at the hospital. So there are a small proportion that have not been referred. The other criteria is if someone has more than three presentations in 12 months, on the fourth presentation they are not being referred to us. But we will offer. The youngest we have had is 16. Our most common referring age across the board is 17 and the greatest presentation group are young females aged between 17 and 21 years.

Ms JODIE HARRISON: What happens with The Way Back?

Ms ADAMS: We are a non-clinical service. Our support coordinators are non-clinical. We have clinicians sitting behind offering governance support, we offer individuals three months of care coordination support following a deliberate self-poisoning. What that means is twofold. 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.

The other unique thing about the service is we have formed an integration with the hospital, so our staff attend the hospital on site each day, go on the ward rounds with the toxicology team and are introduced to individuals then and there. Then we follow up with them once they leave hospital. We have organised a unique unpaid secondment arrangement that allows a non-clinician to sit alongside the hospital staff. That also ensures we are not missing anybody referral-wise. We are doing all the legwork of writing up the referrals and checking with the doctors if that is appropriate. In terms of access it has ensured that we are seeing 48 referrals a month.

Ms JODIE HARRISON: Is it opt in? If someone has been held in hospital against their will for a week, does that person at the end of it say, "I'm not going to," because you cannot force the person to do that?

Ms ADAMS: It is purely voluntary. We meet them at the emergency side, which is not the mental health. At the Mater, you cross the hall and go into the mental health side. We are at the emergency department side of things, but we track their admission. We go in and meet them in the hospital. We work with social workers to try to do that if we can. But then we watch for when they are discharged and then we are in contact from the moment they are discharged. Being admitted, scheduled or anything like that into the mental health unit does not preclude our involvement.

Mr MICHAEL JOHNSEN: I am going to give you a question on notice. I am happy for you to get back to the Committee on this. I preface it by saying you talked a lot about coordinated approaches, government agencies and non-government agencies, small community groups and whatever the case may be. There are a lot of people involved in those service provision areas, but at the same time we hear about a lot of gaps in provision—whether it is that people do not know about the services, provision on certain types and those sorts of things. You call for the multi-sectoral approach to suicide prevention, maximising efforts and reducing duplication. My point about that is that you are delivering it, so what are you doing about it? What does the coordinated, collaborative, whole-of-government and whole-of-community approach look like? What are the gaps? Given that you, collectively, are the drivers of this, what are your perceptions of the gaps?

The CHAIR: Thank you all for appearing before the Committee today. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

Ms SKEHAN: Yes.

(The witnesses withdrew)

(Short adjournment)

TODD HEARD, Clinical Leader, Aboriginal Psychologist, Wiyiliin Ta, Hunter Child and Adolescent Mental Health Service [CAMHS], affirmed and examined

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

The CHAIR: I welcome our representatives from the Hunter New England Local Health District, Child and Adolescent Mental Health Service, including Wiyiliin Ta and the Hunter New England Central Coast Primary Health Network. Thank you for appearing before the Committee on Children and Young People today to give evidence. Can I please confirm that you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses?

Mr HEARD: Yes.

Dr NAGARSEKAR: Yes.

Mr DiRIENZO: Yes.

Mr MOWATT: Yes.

Ms MENDELSON: Yes.

The CHAIR: Would any of you like to make a brief opening statement before we begin with questions?

Mr DiRIENZO: Yes, I would, if that is okay?

The CHAIR: Yes, please.

Mr DiRIENZO: Good morning and thank you for the invitation to be here today. This inquiry is important as it helps us shine the spotlight on this very important issue. With around one-third of Australia's young people living in New South Wales the efforts to identify gaps as well as opportunities for improvement in our system will have significant impact on the overall youth suicide rates. Suicide extends beyond the death of one individual. It significantly impacts families and communities. International research has shown that a systems approach to suicide prevention has the most promise for reducing suicide. It requires a coordinated and combined effort from all levels of society.

The New South Wales health system has an ongoing commitment to reducing suicide and ensuring that people who are at risk of suicide receive effective care. As a system, we are moving towards a more coordinated and integrated approach to suicide prevention. In this I must recognise the role of our non-government organisation partners for the pivotal role they play in this space. Our approach to suicide prevention is guided by the Mental Health Commission's strategic document Living Well. As part of the actions recommended by Living Well, a number of partner organisations have developed a systems-based strategic framework for suicide prevention. This framework is called LifeSpan.

LifeSpan involves the implementation of nine evidence-based strategies and is the largest suicide prevention trial of its kind in Australia. Using the LifeSpan systems-based approach the Black Dog Institute estimates that it may be possible to prevent more than a fifth of suicide deaths and a third of suicide attempts. Complementing LifeSpan is the New South Wales Government's establishment of a Suicide Prevention Fund to support people at risk of suicide across New South Wales. Some $8 million has been invested in the fund over four years from 2016-17. The fund provides opportunities for non-government and community-based organisations to deliver local suicide prevention services and activities.

Among the eight projects supported through the fund is one specifically focused on providing suicide prevention activities for Aboriginal people. Coomealla Health Aboriginal Corporation is being funded $796,000 for the Three Rivers Suicide Prevention Project, which focuses on both Aboriginal young people and adults. It establishes a specialist team to provide health promotion and suicide prevention interventions in the Far West of New South Wales. In my local health district our child and adolescent mental health services provide assessment and treatment, and work in strong partnership with other providers to support children,

young people and their families and carers. My colleagues from the service are here with me today and will be able to discuss in detail how our service works within a broad systemic model, seeing the young person in their family and social context and engaging with multiple stakeholders to wrap services around the young person and their families or carers. Each local area has specific arrangements in place.

In the greater Newcastle area the young person and their families can be supported by the Wiyiliian Ta team who work in partnership with local Aboriginal providers like the Awabakal Medical Service. The team includes Aboriginal counsellors, a social worker, a dietician and clinical psychologists. Our district also has three School-Link coordinators. Part of a statewide initiative across some 3,000 New South Wales schools and TAFEs, our School-Link coordinators, located in Tamworth, Taree and Newcastle, work collaboratively with schools to provide advice and support and identify students who may need intervention from specialist mental health services. The school environment is the perfect place for health and education professionals to work together to help young people with mental health issues. By providing support and solutions early we can dramatically improve outcomes for children and adolescents struggling to cope or who are facing an emerging mental illness. Thank you.

The CHAIR: Does anyone else want to make an opening statement? No, okay. I will start the questioning. We have seen the rates of suicide in young people increase but we have also seen the rate of self-harm increase, particularly with young girls. Is there a nexus between the two and is there something that stands out that we could be doing earlier to stop the self-harm and prevent it going on to be a suicide attempt? I am not sure who to direct this question to?

Dr NAGARSEKAR: We know that a lot of young people have different ways of expressing emotional distress and engaging in self-harm. We are focused on wrapping services around young people to build capacity in the family and other systems around them, including school and other agencies, to manage that emotional distress and to help them so that they do not resort to self-harming. We are rolling out some workshops to professionals and to families. We have Staying Connected workshops, which deal with staying connected with young people when their emotions run high. It is about maintaining that connection and helping them to get over that wave of negative emotion. We have also incorporated into our clinical practice a family-based approach at the initial assessment. It involves multiple stakeholders, schools and other agencies that might be involved in the young person's care to equip them with the tools and strategies they need to manage emotional distress. We are hoping that if we can bring supports to the young person at the time of emotional distress we will reduce the need for them to resort to self-harming.

Mr DAMIEN TUDEHOPE: How many bodies in your local area or district provide suicide prevention or self-harm prevention programs?

Mr DiRIENZO: I do not have that information with me.

Mr DAMIEN TUDEHOPE: Why not? Mr Donnelly asked a question of a previous witness about a snapshot of all the services that are available. Do we have a plethora of services, to what extent do they talk to each other, and where do they get their funding? This industry has significant support, but there do not appear to be real eyes on achieving a coordinated approach. I am wrong in saying that?

Mr DiRIENZO: I do not think that is correct. We do have a coordinated approach and a good directory of all the services that we provide. The challenge is always the navigation of those services. I do not have the information with me today to detail our services and resources. I was not aware that information would be required, but I can provide it on notice.

Mr DAMIEN TUDEHOPE: Is there some sort of directory of all the services available in the Hunter that potentially deal with suicide or self-harm prevention in young people in this area?

Mr DiRIENZO: I can provide an example of something that might address that concern. One of the things we have been working on for a few years with our primary health network partners is a service called Community Pathways. The pathways assist in first principle general practice and primary care and the community. We have worked together to establish a range of pathways, all evidence-based and with the latest evidence about the model of care and how we should navigate through the system. We are using that partnering with our general practitioners because we know they play an important role in that setting. We have pioneered that across the State as a local health district. That is an example of how we can try to connect the system, and in that particular example by using general practice as the navigator on behalf of the family and the patient.

Mr DAMIEN TUDEHOPE: You identified in your opening statement and in that response primary areas on which you focus to ensure that service providers have contact with the education system and general practitioners.

Mr DiRIENZO: That is correct.

Mr DAMIEN TUDEHOPE: I am a parent and I have an issue, where do I go?

Mr HEARD: The general point of community access to specialist mental health services is through the mental health contact centre, which is a state-wide contact service.

Mr DAMIEN TUDEHOPE: Is that a family friendly unit? I am a parent with serious concerns about the behaviour of one of my children and I need guidance about where to go to get support.

Mr HEARD: Yes, it is, and it is staffed by allied health workers. You would be put in contact with an allied health worker who would do a basic triage. It is similar to the procedure you would go through when you presented to hospital. They look at the presenting issue and how you might best be supported and whether that is within a health service or a nongovernment organisation. If it were a nongovernment organisation, you would probably be referred to the NSW Family Referral Service, which I think is offered through the Benevolent Society. It has a role in connecting you with nongovernment supports in the community. They are the two main avenues. Aboriginal community members have a third pathway through which they can contact our service directly. A family can make contact directly with our service or the Aboriginal Medical Service can contact us directly to make a referral. It is acknowledged that the first pathway might not be okay or acceptable to Aboriginal families, and it offers a third pathway.

Ms JODIE HARRISON: The Where There's a Will submission to the Committee included a factual story about a 16-year-old male who attempted suicide. His parents made contact with the service providers recommended to them by Where There's a Will. However, the parent did not use the correct language, and as a result he could not get an appointment for eight weeks. How can that happen?

Dr NAGARSEKAR: Mr Heard mentioned the Mental Health Hotline. We do a triage and we have the capacity to offer a 48-hour urgent appointment when young people might be at risk of suicide. The people who do the triage are mental health clinicians trained in assessing and triaging children and adolescents who might present with mental health problems. The people who work on the Mental Health Hotline are mental health clinicians who are trained in assessing the mental health problems that children and adolescents present with. They can triage children and adolescents who might be at risk of suicide into a 48-hour urgent appointment in the community to help them to gain access to community follow up as urgently as possible. They can also direct people to take them to a hospital emergency department if required based on the risk. I cannot comment on that specific case because I am not sure what happened. But, ideally, they would have been given an urgent 48-hour appointment with the local community health team or been sent to the emergency department for a mental health assessment if that was required and if they were at risk of suicide.

Mr HEARD: I cannot comment on that case specifically, but it would depend on the advice provided to the parent about where to make contact. There are different avenues for families to access support. We have the Child and Adolescent Mental Health Service and other primary healthcare supports. That might include headspace or other private allied health workers, who are federally funded often through Medicare or self-funded. It would depend on what advice was provided to the family about which avenue they should follow. From a CAMHS perspective, they would be offered either a 48-hour appointment or a 14-day appointment. Those who are at acute risk are seen within two days and those who are at lower risk are seen within 14 days.

Ms JODIE HARRISON: We know after one suicide attempt the next 72 hours is—

Mr HEARD: Correct.

Ms JODIE HARRISON: Eight weeks is—

Mr HEARD: I agree, 100 per cent. The point I would make is that it depends on the advice provided to the family about what avenue they did take to seek advice or support. When it comes to primary healthcare referrals if it is on this side it could be headspace or a private psychologist. Then the issue would be around wait-time generally experienced for that provider. But from a health service perspective there is the guarantee of support within 48 hours or 14 days.

Mr MICHAEL JOHNSEN: As a Government agency covering health and mental health, why do you think we are spending more and more money on this issue with rising rates of suicide?

Mr HEARD: I guess it is a phenomenon that has been looked at. I guess in developed countries it is a rising issue. Among developed countries I guess it is about understanding what it is about developed countries that creates and grows these issues. It is really quite a big question to ask, but from a young person's perspective I guess it is multi-faceted. There are a number of issues around the pressures of life early on. In early years, say,

we might see emerging developmental issues which might occur for a number of reasons. Then it is about access to support during those years.

In the later years it is around demands that are put onto young people these days. They are probably much greater than they might have been historically. Individually, I reflect on this myself with respect to my daughter. Now, literacy and numeracy is a very big thing in kindergarten, when historically it was not a kindergarten issue. Kindergarten was a time when we were getting them ready for school, but now they are teaching literacy and numeracy. For me, looking from the point of view of a developed country, I was thinking that that is quite a big change. The pressure of this is brought all the way back to an early age, when before it was at a later age. I think it is a really big issue. It is an issue that developed countries are having to deal with. I think it comes down to the stresses and pressure that come along with that, and how we support families and young people to live well in that type of environment. That is really where the focus needs to be.

Mr MICHAEL JOHNSEN: I will touch on your point about how we help people—teach them or whatever the case may be—to live well. To me you are getting back to the core of the individual and their immediate family networks as well as friends and community and so on. What can you do better? From your professional experience, what gaps do you identify, from the perspective of your agency, that could be fixed to assist in that process, rather than just focusing on after-event care?

Mr MOWATT: I think there has been a recognition by our service over a number of years that the referral base that we see is quite different from what it was some years ago. There is an increase in acuity; there is an increase in complexity. Child and Adolescent Mental Health Service has recognised that and tried to offer a different way of responding to families who present with mental health concerns. We are paid to treat mental health conditions and our view is that, especially with kids, working with the family and/or whatever supports are around them, is the best way to achieve a positive result in the end.

So it is not just about self-harm or suicide prevention, from our perspective. Obviously that is very important. We are seeing a lot more people who do present with self harm and suicidal ideation, but they are not necessarily the same thing. We have tried to change the way we do things so that we offer, in line with the changing demographics that we are seeing, a very thorough assessment. Then there is a period when we try to bolster the support and stabilise the support around that family. Then collaboratively, with the family, we can make a decision about where to go next. That might mean remaining in CAMHS for further treatment or a referral on to another agency.

Obviously CAMHS can only operate within the constraints of what we have. I think that what we do is a very good job within those constraints. We cannot be all things to all people. So, we have tried to be very good at what we do do.

The Hon. CATHERINE CUSACK: The submission we have is that the most vulnerable young people are people who are not with their families—who are institutionalised or homeless or whatever.

Mr MOWATT: I would agree with you.

The Hon. CATHERINE CUSACK: It just worries me that the focus has gone onto that when it seems inconsistent with the most at-risk group.

Mr MOWATT: It might seem to be inconsistent but I disagree that it is inconsistent. If young people are within a family then that would be the primary context which we would look at. Obviously there are a proportion of young people who do not come with their family—who do not have a family to come with.

The Hon. CATHERINE CUSACK: That would be the most at-risk group.

Mr MOWATT: It is one of the most at-risk groups, yes.

The Hon. CATHERINE CUSACK: Can you name me one—

Mr MOWATT: What I was trying to say was that if a young person arrives without a family we would work with whatever the context was that that young person operates in. If they were without a family we would look at: who is the young person living with, are they attending school?—any of the natural kinds of support networks that may be around. We would work with them to try to bolster the support around that young person.

The Hon. CATHERINE CUSACK: We had evidence that in this area there are no youth counsellors available. Who are the people who would be doing that work?

Mr MOWATT: When you say that there are no youth counsellors what do you mean by that?

The Hon. CATHERINE CUSACK: A youth counsellor would be a person that would be engaged by the health service to deliver those services. We are hearing that the youth programs are not available locally—that they have to travel out of this area to access those services. Are there services available here?

Mr MOWATT: Do you mean within the health department?

The Hon. CATHERINE CUSACK: I am talking about in Singleton.

Mr MOWATT: There are counselling services available but—

The Hon. CATHERINE CUSACK: Not for youth, though. I am just wondering who would do the work that you have just described here in Singleton as an example.

Mr MOWATT: Mostly, at this stage they would have to travel to Maitland, where the CAMHS Hunter Valley team is based. We have recognised that this is an area of need, and we have moved resources to the Upper Hunter. We have placed one staff member at Muswellbrook and we are going through the process of employing another mental health clinician for Singleton as well as Muswellbrook. So we are aware that people in Singleton have had to travel. We are trying to address that, as I said, within the constraints that we have.

Mr HEARD: Further to John's comment around how we view family units for young people in care or for people who do not have family around them, it is individual to them. So actually the support systems that sit around them are viewed as a family for them at that time. It is a bit more of a complicated family picture than someone generally, so it really depends on individuals. For our service, of course, it goes much broader than that. We have community organisations and other family groups and services that have to sit around the young person, as well. But it is really individual to the person.

The Hon. PAUL GREEN: I just want to come back to Ms Harrison's question about triage. Obviously in a hospital the nurse sits behind the bench. The nurse knows how the system works, but as Mr Tudehope says, the patient does not. The patient comes in hoping the experts will make the right decisions about that care, and give further information about the treatment and so on, until the person goes home. I guess the concern for us is you have a triage system for mental health. The parent comes in not knowing from a grain of salt what to expect—you are the experts—and they send them home saying eight weeks for an appointment. The question is, that happens in a hospital and it is not unusual that someone can be sent home with chest pain thinking it is muscle pain and have a heart attack, or a rash that is suddenly meningococcal disease, that happens. What do you have in place if that parent is not happy? Is there a backup system to go to rather than the same people who might start to stigmatise you as being a mad parent. Where does that parent go, what are the options?

Dr NAGARSEKAR: We have really worked a lot on trying to build pathways from the emergency department to the community Child and Adolescent Mental Health Service. What we have done is we do not want people to leave the emergency department if there is significant risk of suicide and not have an appointment with the community CAMHS team or have an appointment after eight weeks. What we have done is we help the mental health line identify urgent appointments in the local area. For example, if someone from Singleton presents to the emergency department at John Hunter Children's Hospital following an attempt, if they do get an assessment the registrar or psychiatrist, whoever does the assessment, can actually call the mental health line at two o'clock in the morning and get an urgent appointment at Hunter Valley CAMHS team at Maitland for that particular young person or the family within 48 hours.

Of course, not everyone who presents to an emergency department needs that appointment. We need to make sure it is only for people who really need it. Those who do not need the 48-hour appointment get a response, a face-to-face assessment within 14 days. It is only if they might have been discharged to their private care provider or a care provider at the primary healthcare level, for example, headspace, that there might be a delay. I cannot speak for headspace or other agencies. If they need a follow-up within Child and Adolescent Mental Health Service in the community teams they will get one within 48 hours or 14 days.

The Hon. PAUL GREEN: If you take the case we are talking about, before you cross the line—and I am not an expert on suicidal ideation—you go up to that line. It seems in this case they walked up to that line and did not present with that ideation, but eight weeks later has that situation arise. It could have been cut-off before they got to that line. I am a bit worried that you have to present with the three points of suicide issues. Prevention is better than cure. Surely in a situation where they cannot be seen for eight weeks you would say, "but we will refer you immediately to your GP."

Mr HEARD: With that case we do not know and cannot comment specifically around whether they presented to a health service or a primary care referrer. If they presented to a primary care referrer, from a health service perspective everyone who called would be given advice around other options as well. Such as present to

the emergency department [ED] or those services they might access. They are all given options. If it is not a point of crisis now they would be given some information around primary care referral options they have.

The Hon. PAUL GREEN: The reason it worries me is that from what we are seeing in the research as we go through the evidence is there is becoming a new section of suicide where there is no warning. It is quite a large proportion. How are you, as professionals, going to deal with that, because it will not present as an emergency situation?

Mr HEARD: 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 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. I guess there have been resources developed in partnership with community but what I see sometimes is there is no investment to support the implementation or follow on from them.

There was a resource mentioned earlier today, Conversations Matter, it was commissioned for development, not commissioned for implementation. So we have this wonderful resource that has been developed in partnership with community but there was no secondary component which is around we have this great resource which is online but actually the follow-up one is now it needs to go to community and have those community conversations. That is where things fail for me. There is investment at this end around let's develop something, but then there is little investment in saying let's get it to youth, let's get it to parents and let's get it to the community. Sometimes that is where I see it failing.

The CHAIR: On the other end of the spectrum, what follow-up is available upon discharge?

Dr NAGARSEKAR: From our point of view often the discharges are from the emergency departments or children's hospital or the child and adolescent mental health inpatient unit, which is Nexus at John Hunter Children's Hospital. We worked on the transition policy from hospital to community. What we have done is we have given the community CAMHS teams the tools to be able to identify young people from their area who might be in the hospital. There is the electronic patient journey board they can look up every morning to see if there are young people from their area in the hospital. Based on that they can make contact with the treating team on the inpatient unit. Even the treating team has a care coordinator assigned to each and every young person who is admitted who can make contact with the community CAMHS team.

If they are in the children's hospital we have what we call the consultation liaison commissioners who offer the assessment and make contact with the community CAMHS team, and they do so even for children and adolescents presenting to the emergency department. 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 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.

The CHAIR: Are there gaps you are seeing?

Dr NAGARSEKAR: One of the things we have tried to address is to reduce young people travelling from one emergency department to another emergency department, especially for rural and remote areas. Telepsychiatry is one way of addressing that gap: to supply telepsychiatry to emergency departments in rural areas. Another way is to build capacity in local emergency departments to do mental health assessments, for example, in the emergency department in Maitland hospital. We are also working with medical officers working in ED to help them do risk assessments and mental health assessments. They are not mental health clinicians, they are general medical officers and we are trying to help them identify risks and do mental health assessments in the ED when children and adolescents present there.

Mr HEARD: Another cohort of at risk young people are those that present to ED quite regularly. It is not uncommon for a young person not doing very well to present five times a week to the emergency department. There is a new program that started called the Youth Engagement Service [YES].

Mr DiRIENZO: The Youth Engagement Service.

Mr HEARD: That is around working with this cohort of young people that present regularly to emergency departments to provide them with extended care around looking at making sure they engage in actual support. If they are not in the position or willing to engage in support, it provides them with some case management-type support with the aim of transitioning them to some ongoing service. That is a new initiative.

Mr DAMIEN TUDEHOPE: That is a good initiative, because another indicator may be truancy. Regular presentation at hospital, failure to turn up to school, perhaps coming to the attention of the police—these are all indicators.

Mr HEARD: I was reflecting on it because of early intervention supports. I was thinking that once you hit the juvenile justice system—you have been charged or are at risk being charged—then you have some early intervention supports available to you, such as mentoring and other supports that might provide you with social support. When it comes to general community social support for someone that has not committed a crime or is starting to struggle a little, there is not a lot of mentoring support.

Mr DAMIEN TUDEHOPE: There is Youth on Track, is there not?

Mr HEARD: They are only available in very specific areas. It is about where they are delivered to, so some of the programs like that might have a base in schools or something like that, whereas some young people do not want to engage with someone like that in schools. There are very limited supports when it comes to youth mentoring. If you have committed a crime then you have the juvenile justice system that will sit around you to try and prevent further crime, but prior to that there is not a lot of support early on. We have to prevent that progression.

The Hon. GREG DONNELLY: We have received some evidence from the New South Wales Child Death Review Team about the suicide rate for Aboriginal and Torres Strait Islander people under the age of 18. The evidence indicates that from 2012 to 2016 there was an increase from 1.7 to 4.65, which in percentage terms is quite high. I will choose my words carefully because I do not want people to take offence. Do you believe there is a valid argument for the government of the day to recruit more qualified people to work in community social work with Indigenous communities—in other words, the close interface with the communities—and particularly the young people with mental health issues and, in the worst instances, suicide ideation?

When I talk about qualified people, I am talking about people like senior psychologists and psychiatrists as well as people with medical training. In principle, should people with medical training be closer to the at-risk groups to provide early intervention? Should we be working towards that, as opposed to the model where the close interface is with individuals, some of whom are qualified social workers? My argument is that health professionals are a step closer to the coalface, and greater numbers of medically qualified people could be embedded in this interface with the youth at risk in Indigenous communities, so as to assist in providing early intervention, which may lead to a reduction in suicide. Is that a valid proposition, or are we currently on the right track?

Mr HEARD: I want to qualify that we have clinically trained people and we have cultural experts, which bring exactly the same thing to the table. We are doing 110 per cent the same thing together. We work together in partnership because a clinician independently cannot work if they do not have cultural knowledge. Cultural experts alongside clinical experts working together is important. I needed to caveat that.

The Hon. GREG DONNELLY: I am not arguing against that.

Mr HEARD: I think you are right that closer alignment between services and community is important. In the history of Wiyiliin Ta, for example, it is now 20 years old. You have to go through a period of time where community are getting to know you and trust you. Being known and trusted then you can have early intervention conversations as opposed to acute risk conversations. That only comes with time and commitment and that connection. Without those things, generally from an Aboriginal community perspective, you only present when things are really, really difficult. If there is this interplay between community and clinicians then you are able to have earlier conversations alongside of high-risk conversations. That only comes through relationships and closeness and being trusted.

I guess that is why the Wiyiliin Ta model continues to grow and evolve and why it has been successful for 20 years. Nationally, it is a Burdekin-funded program from 20 years ago and the Burdekin report. It is one of the only programs that still continues as a result of that report. It is an investment in this area and it is a model that works. It is about there being support over time to see whether that model, if it was expanded or grown, would have the same benefit on the community.

The Hon. GREG DONNELLY: Would you argue prima facie that it would work?

Mr HEARD: Yes.

The Hon. GREG DONNELLY: If a boat is floating and you put it in another body of water, it should still float.

Mr HEARD: Assuming the ingredients are the same, yes. The uniqueness of this model is that Aboriginal and non-Aboriginal people work together. That is part of what the model is built around and probably part of its success.

Mr MICHAEL JOHNSEN: In the context of staffing for the delivery of services I will use Nexus as one example. We know that mental health workers have to deal with intense emotional and professional pressure day in and day out. What is the average length of service for staff at Nexus? Is there a turnover in staff delivering these services through natural attrition or through management or both? How do you keep people refreshed in this field? Is it difficult to get staff?

Dr NAGARSEKAR: We have been through a change process in the Child and Adolescent Mental Health Service inpatient unit at Nexus at the John Hunter Children's Hospital. One of the things that we have worked towards is what we are calling creating a positive culture of care, which came to us from the ministry. A lot of it is targeted around supporting young people when they are on the unit and also supporting staff. Part of creating a positive culture of care on an inpatient unit is debriefing for staff who work with significant emotional distress on the unit with a lot of acute presentations to the unit. We recognise that, and the program also talks about leadership of the unit and how leadership can be involved in supporting staff who are working on the ground. That has brought about some change to the unit—some really positive changes that include, for example, a reduction in our seclusion rate. We have reduced our seclusion rate considerably, almost to zero.

We have also improved on the youth experience survey that we offer young people who come to stay on Nexus service to gather how their experience has been on the unit. That has shown significant positive changes. It was presented to the inpatient benchmarking forum just a few weeks back. We recognise the staff is extremely distressed on the unit, especially when there is acute distress, and we try to target that through that particular program. But other programs that are helping the unit include Productive Ward so that we can release more time to clinical care—improving the day-to-day running of the ward by organising the ward in such a way that staff find it easier to find things, for example, and are able to release more time to actually care for young people who are admitted to the unit.

Mr MICHAEL JOHNSEN: Do you measure the success of these management initiatives and so forth? Where are you getting your feedback from? Is it from the staff or from patients and their families? Is the intent of the delivery being matched by the experience?

Dr NAGARSEKAR: The youth experience survey is collected on Nexus from young people who are admitted to Nexus. That goes straight to the ministry. Then they collate the data and present it to us at the inpatient benchmarking forum. The seclusion rate also goes straight to the ministry and they present the data to us. Those are the two main things that we have focused on, but there is a lot more that we can focus on. As a team, we are coming together to think about what other data we can gather that would be a true reflection of how the programs are working on the unit.

The CHAIR: Ms Mendelson, we have missed you. Was there anything you wanted to add?

Ms MENDELSON: Yes, I was just going to say, I appreciate it was not part of these discussions. We work in the prevention and intervention for youth, and I think that is where the biggest changes can happen and are happening. To give you a really quick example, we are literally in the process of designing new services for youth complex. The way that we are doing that is with the local community. We had one in Glen Innes and Narrabri last week and we are in Muswellbrook on 12 December. The difference with this is, like I said, it is a new service and it is going to be designed by local people. Obviously we are partnering with the local health district [LHD] but, more importantly, the young people, school leaders, parents, schoolteachers and people that work with young people. It is going to be a totally different perspective. We know that when we do service specifications intended for this service we are getting a service that is absolutely critical and, more importantly, appropriate for those local communities.

The CHAIR: I would like to direct some questions to you, perhaps on notice, because you have a vast region that you cover and I would particularly like to know the differences between the areas you cover.

Ms MENDELSON: I want to acknowledge that everything you have said in a few of these discussions has been highlighted through our mental health and suicide prevention needs assessment. Coming back to what you said originally and one of your first questions was that when we are talking to parents they do not understand the language and they cannot navigate the system. What makes it even more difficult is with all the services changing names. And if they do get to GP, they do not even know what they are supposed to be asking, so we are doing a lot of work in that space as well to educate and for their health literacy as well.

Another example that kind of encapsulated all the questions you were asking is that we have partnered through a co-funding and co-commissioning project with the Central Coast Local Health District. It involves us,

the LHD, the Department of Education, Family and Community Services, and the Benevolent Society, which is a non-government organisation. It is basically a model that is delivered in the school and the community of Brisbane Water. We have a young person working within that school. It is the Family Referral Service, but it works in a totally different way in that we are actually working in the school and identifying those vulnerable families and vulnerable children. We have the person-centred approach around that family and around that person. We pick up those vulnerable people from those indicators that were mentioned earlier.

We are getting some really great outcomes from that. It is a co-commissioning, co-funding model, where everybody is committed and we have all the right people around the table as well. Once again, the work we do is prevention and intervention, and I appreciate that was not part of these discussions but there is a lot of work happening within that space. We are going out of way to work with local communities. You will hear from Where There's a Will later—an absolute beacon of light of what can be done in building resilience and education in schools. We are shortly facilitating a discussion with Where There's a Will with Central Coast Local Health District. We are going to be looking at whether that model could work in that area and how it can be replicated and what have you. That is the primary health network's [PHN's] role as well.

The CHAIR: We never know the direction the questions will go, so I apologise for that. I finish by saying thank you to you all for appearing before the Committee today. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to reply a written reply to any further questions?

Ms MENDELSON: Yes.

Dr NAGARSEKAR: Yes.

Mr MOWATT: Yes.

The CHAIR: Thank you very much. Thank you for your time.

(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

The CHAIR: I now welcome representatives from Headspace Newcastle, Headspace Maitland and Where There's a Will (Upper Hunter). Thank you all for appearing before the Committee on Children and Young People today to give evidence. I confirm that you have been issued with the Committee's terms of reference and information about the standing orders that relate to the examination of witnesses. Does anyone wish to make an opening statement?

Mrs CARRIGAN: I do, please. Headspace is aware that I am going to do this. You have to know the grassroots of where this came from. The last time I saw my son in the last 24 hours—I am sorry; this has been a big build-up to the day—he was wearing a sunhat and sunscreen mixed with dirt on his arms. That was the very last time. Months later this is the vision of him that I get in my mind and I asked the psychologist, "How does this happen?" How is he still protecting himself from the sun when we know now that he had a plan to take his own life? "Because you taught him that." This is the new Federal Government Head to Health webpage—you have a copy there—with six ways Head to Health can help, including meaningful life, whether you are having mental health difficulties, how to support yourself and supporting someone else.

This can all be covered in positive education and teenage mental health first aid in our schools. Do not keep this information inside the space any longer. I found absolutely everything I needed to know to keep my son alive after he died. Don't assume because you, the primary health networks or anyone else have this knowledge that regional parents or, I suspect, parents across the whole world know this stuff. It is like finding out something after the gate has been opened and the horse has bolted. I know of another five parents who have lost their children in the last five years who had no warning at all. We thought we had very strong, healthy, bouncing children and overnight they were dead. That is when we found out about the crisis, not the day before or the week before.

Everything on that page is based on Martin Seligman's Positive Emotions, Engagement, Relationships, Meaning, Achievement [PERMA] model. He actually visited Australia recently and in a speech he said that Australia is leading the way in positive education. That shocks me. Why? Because the Positive Education Schools Association [PESA] freely assists other schools to take the knowledge that is in the books and deliver it in a school-based curriculum. It really assists schools to navigate their way to retrain their teacher. The Upper Hunter is using the PERMA; we are using this PERMA model in our schools. We have 19 principals who meet every eight weeks to share the knowledge on the ground.

We have sporting groups and service groups; basically the whole community have joined together. We have decided that this is the way that Upper Hunter is going. We have drawn a circle in the sand and we wish we could share it with Australia. Ms Geerin has just taken over measurement with Peggy Kern and Michelle McQuaid out of Melbourne University and they will be measuring, as of 2018, the consequences of actually going down this track. That is us for an opening today and I thank you very much. I am sorry I was very emotional.

The CHAIR: That is completely understandable.

The Hon. PAUL GREEN: You said where there is a will, there is a way. In your submission you said clearly not to leave parents out of the initial findings. You said it was moulded around the school but you said that parents should be involved in the care and be made aware. The reason I say that is such an important statement is that we see more and more politically that the education department is moving away from involving parents, particularly in matters of sexual identification, where they are trying to separate children from the family unit. You clearly in your submission talk about embracing the family as early as possible to be able to address this situation?

Mrs CARRIGAN: Yes.

The Hon. PAUL GREEN: Do you want to clarify that comment?

Mrs CARRIGAN: Most definitely. The Government is outsourcing families. If we go back to the things we have learnt, the one thing that is on television every time we talk about mental first aid is, "Ring Lifeline". When is anyone going to say, "If you can't talk to your parents; if you can't find a friend, how about then you ring Lifeline". Stop training our children to think—and it is drug and alcohol problems or sexual problems which lead to mental health; how about we start to create the family again? We can create the family, yes, with this Federal Government webpage, but take it away from here. This is not good. This is actually admitting that you know what the problem is but you have not taken another step to put it where it needs to be. Unless a person is sick, why would they go there? It is like looking for a cure for cancer when you do not have it. It is too late. You cannot create a meaningful life for yourself once you have already gone down the tunnel of hopelessness.

The Hon. PAUL GREEN: I ask a question about headspace. I notice you have a service manager in Maitland and a service manager in Newcastle. Why do you have one in Maitland? Does it have an appropriate sized population to have a particular group? I ask that because I think of somewhere like Lithgow that also needs a similar service but only has access to Bathurst or services in Sydney. With Maitland being smaller and having Newcastle just down the road, how does your model work? How is it funded and how many days does it operate?

Ms SCOTT: There are probably a couple of aspects to that. I am not really sure if you are aware about how the headspace model works. Each headspace centre could potentially have a different lead agency and in our circumstance that is the case. Our lead agency is the Samaritans Foundation and Newcastle's is Hunter Primary Care. We are funded quite differently. Maitland potentially has a larger geographical draw area than Newcastle, and we have significantly less funding than Newcastle. That is not our decision to make; it started with the Federal Government when it began funding the National Youth Mental Health Foundation, which was headspace National. We have no say in how that happens and what it looks like. The increase in funding has not been there, but headspace Maitland has been very lucky to get top-up funding after a submission made earlier in the year to get a headspace hub and spoke centre from our place. We put together a submission together to be able to run a headspace centre for three days in Muswellbrook. We were not successful through the Department of Health, but we did get some top-up funding.

Other than that, no CPI is applied to our funding. There has not been a significant, or any, increase in our funding taking into account the growth of the area. None of our resources have changed to accommodate the new real estate developments in the Hunter region. Our funding limits us to the services that we can provide because we work on the Medicare model. We are funded in a way that we can and we have a certain percentage of staff and the rest is outsourced to private practitioners who can bill only the Medicare fee. We really have to find a specific skillset and passion in a person to want to do that because in our centres they can bill only $84.80 a session if they are a psychologist, but in the community they can bill between $135 and $185 a session.

You have to find the right people with the right passion to work within our services. We have a manager each because we are different lead agencies. We provide the same four core pillars because we are headspace services, which is mental health, primary health, education and vocation, and drug and alcohol work. However, each service is run differently, and that is true nationwide based on the communities that we support, the client groups that come in and the other resources that are available to refer out or to get our referrals.

The Hon. PAUL GREEN: Is the "hub and spoke" something that headspace in Maitland has come up with, or is it a model that headspace has come up with nationally?

Ms SCOTT: No, headspace nationally floated the idea a couple of years ago and then the primary health network said some money was available earlier this year. Centres in different areas had proposals. Port Stephens is another area that needs more services, like Lake Macquarie and upper Hunter. The community mental health requirement is big. We recognise that and we have figures and statistics we can use. We knew there was not a lot of money to provide full services here and there. We put in expressions of interest in response to what was there at the time.

Mr HIRNETH: In regard to the comment about why some areas have headspace and some do not, interestingly, some of the more recent projections have shown that we need about twice as many headspace centres to cover the population. We are about halfway there.

Mrs CARRIGAN: I would like to speak about headspace. We work a lot with Ms Scott and she helps us. Our children do not know headspace Maitland exists. If you are going to wait for a suicidal episode and then refer them to headspace, as I said, the horse has bolted. We are working with headspace at the moment as part of the normal teenage journey through school. We present teenage mental health first aid in year 10 along with a visit to the headspace web page and we go through the registration process. If you were suicidal and had to register before having an e-chat, you would have gone over the edge with frustration. We have piloted a live

chat between a class and a practitioner in Melbourne. The practitioner knew about it beforehand and the children decided on the problem they would present. They typed it onto the page and the practitioner responded. We want to destigmatise crossing the line into sharing your problem. If we could get a headspace in Muswellbrook, we would be laughing. But I imagine it will all come down to finances.

Ms SCOTT: That is a Ministry of Health issue.

The Hon. GREG DONNELLY: Did you say that the live feed involved a whole class or was it an individual in a class who was having some difficulties?

Mrs CARRIGAN: No, it was a pilot program. We used the agricultural group in Merriwa. Merriwa was having a day on agriculture that separated two groups of 15 children. They asked whether they could present something to the children as part of mental health in agriculture that week. Where There's a Will has no resources of its own. We believe that most resources already exist, so we seek out what we need and bring it home. I approached Ms Scott about a registration exercise and a live chat to Melbourne. She took them through it and they registered and had the live chat.

The Hon. GREG DONNELLY: Do you recall what the problem was or was it hypothetical?

Ms SCOTT: It was a hypothetical problem. Initially the young people decided they wanted to say they were suicidal. The process involves answering a series of questions on e-headspace. When we got into the chat with the clinician online, they said they were being bullied at school and so on. It was about showing them what a session online looks like. When we got to presenting the problem in the typed section, they did not bring up suicidality. Just before the session ended, the practitioner said, "You mentioned that you were feeling suicidal and that you wanted to end your life. Can we talk about that?" It was definitely a hypothetical conversation, but it was certainly about things affecting the children in those communities at the time. It was a good reflection of that.

Mrs CARRIGAN: They spoke about teenage pregnancy, alcohol and drugs. We discussed with them in the class the types of things on the page that were open for discussion. They could even call on behalf of a friend and say, "My friend is..."

The Hon. GREG DONNELLY: I refer to page 2 of your submission and the reference to "Terms of reference responses". You state:

> There is a significant discrepancy between what is funded by the Government and what is actually delivered in the region. Just because Government funding is allocated does not mean that it is available to the Upper Hunter community.

Do you know that as a matter of fact or is it just a sense of how you feel at the moment?

Mrs CARRIGAN: No. I remember I was told emphatically that six counsellors were already funded in upper Hunter schools. Over six months, I started to realise that that was not correct.

The Hon. GREG DONNELLY: Can you explain that? Who told you that?

Mrs CARRIGAN: I am talking about school counsellors.

The Hon. GREG DONNELLY: What meeting was that?

Mrs CARRIGAN: I do not know.

The Hon. GREG DONNELLY: Okay, that does not matter.

Mrs CARRIGAN: That part does not matter, because I went back and asked someone who knew. 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.

The Hon. GREG DONNELLY: That is what I am trying to tease out. Thank you for clarifying that. Under the heading "Approaches taken by primary and secondary schools" your submission states:

> Schools should be our first line of defence for mental health wellbeing and suicide prevention.

If we take that as a bold statement and say, for argument's sake, "We agree with that proposition", it seems to me that a fair bit of expertise and resourcing should be embedded. If it is not already there in our schools, or if it is partially there, it should be topped up to meet that requirement. I am contemplating what our schools are having to deal with today. To place that as an obligation on our schools—institutions for the provision of education to our children—be it primary or high, and for it to be properly fulfilled would really require some

significant thinking, which would mean resources and the employment of suitable people to be able to achieve that. Do you think we are capable of doing that?

Mrs CARRIGAN: I do not think we have a choice. Whether there are capabilities or not, someone has to start somewhere. The World Health Organization predicts that by the year 2030 depression will be the leading health burden to mankind—that is 13 years from now, and ticking away. Secondly, one in every five students sitting in a classroom is already suffering some type of mental disorder. These are all statistics that are available. You test for NAPLAN. One in every five students cannot sit NAPLAN because they are not feeling well. Then you produce a page like the one on this website where all this information already exists. I know that we are doing it in the Upper Hunter. We have 16 schools studying Visible Wellbeing with Professor Lea Waters as of 29 January 2018, over a two-year period. Our community has just raised over half a million dollars to make this happen.

I am here today because my grandchildren will grow up in the Upper Hunter. They will stand in the pub on Friday night with their friends. So I am going to make sure that this happens here. Can I make sure the Government listens and says, one day, "Yes, this has to be done; how are we going to go about it?" Testing for NAPLAN when half your class are not well is a joke. We know that positive education improves the academic results across the whole school. So, if you are going to keep saying, "We're an institution of academics," you are letting them down because they do not feel well enough to work. When you get out of bed in the morning, your most productive days are the days you feel well. How you feel on those days when you get up half tired or when you have had a late night Friday night so Mondays are really quite bad is how those kids are feeling in those classrooms. Sadly, for them it is not just Mondays. Some of them are going through that on Friday and Saturday.

I would like to take you back to prevention. Prevention has to start in schools. All the money that we keep throwing out there is not working. Every year there are new ideas, new ideas. It is climbing and climbing and making no difference.

Ms GEERIN: Can I add to that? Professor Seligman, when he was over here, presented a paper of research from one of his doctorates, which measured in Mexico interventions which, rather than focusing on improvements in education, focused on improving the wellbeing and the ramifications. By improving wellbeing the people improved across the board, not just academically. If we ask parents, "What do you want most for your children?" and they say, "I don't care, as long as they are happy," why do we keep pushing and not focus on wellbeing?

The CHAIR: At this point, does anyone have any specific questions for headspace, because we have asked Where there's a Will to stay for the next session. I just want to make sure that we utilise headspace's time appropriately.

Mr MICHAEL JOHNSEN: I have two questions. One is for headspace; one is for Where there's a Will. A few years back—five, six or seven years back—headspace in Maitland was telling me that it interacted with quite a few kids from the Upper Hunter who would travel down to Maitland. In their view, part of the reason was that those kids did not want to be stigmatised at home, in the smaller country towns. Is that still happening?

Ms SCOTT: That could be part of it. But most of the reason that young people do not access 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—this is what Mrs Carrigan was saying—they may only have 3.2 counsellors out of the number they were funded for, because the skillsets are not up there.

When we placed our tender earlier in the year we knew unfortunately that we had to draw on the existing skills sets that are in the Newcastle-Maitland area and take them up the valley, because at the moment they are not there. In saying that, if there are clinical psychology students or psychology students who need to do their registration in the Upper Hunter, and we do it will we will be able to keep the skill base up in the Upper Hunter. At the moment for services that are applicable for young people we need to take them to the region.

That would not be the main reason young people do not access Maitland; it would be the travel—the resources and the cost. We had a family last week with a young fellow of 13, who really needed some help. The family was not sure if they would remain with the Wiyiliin Ta service—you heard from them this morning—so they had an intake appointment booked with us. Mum cancelled that appointment because on that day she had three other children who could not go to school because she would not be back in time, and there was the cost of food and those sorts of things. Unfortunately, it is a day out for a family to come down and attend. I would imagine that is the main reason people do not access us in Maitland. We are too far.

Mr MICHAEL JOHNSEN: As a side note it might be worth noting that we—the Government—have started up a bus transport service twice daily, seven days a week, from Singleton to Maitland in addition to the trains.

Ms BURNS: Only to Singleton.

Mr MICHAEL JOHNSEN: Yes, at this stage it is only to Singleton—Singleton to Maitland.

Ms SCOTT: How do we get that information?

Mr MICHAEL JOHNSEN: You can see it on your normal Opal site or Transport for NSW. It is in the normal timetables. That was off track a little. Pauline, Andrea and Jaclyn, in your submission when talking about any gaps in the coordination or integration of suicide prevention activities and programs across all levels, you have mentioned that Where there's a Will does not believe that you were in a position to comment on this term of reference. However, in our discussion Pauline mentioned that you believe that there is enough information there. It is a matter of knowing where to go and get it and how to apply it, and all those sorts of things. Given your experience do you think that you are now in a position to comment on the level of coordination? It might be positive or not so positive.

Mrs CARRIGAN: I am going to hand over to Jaclyn just to give an overview of what we do and do not have. People are not actually holding hands in the services in the Upper Hunter. Between the people who require the services no-one is holding hands. It is very competitive. They compete for funding. They compete to be the best service. To be part of a positive education journey you cannot criticise others. That is why Where there's a Will, without the knowledge, will not criticise. We are trying to build upon what we already have, rather than tear down. I may just hand over to Ms Geerin, who has spent the last three months trying to put some pieces together.

Ms GEERIN: We realised, with the stuff that we have been doing, that we were being stopped during workshops and people would be telling us about the lack of services. We were constantly saying, "Well, contact a member of Parliament; write them a letter and let them know." We got together and said, "We know people are saying to us that they cannot get help and we know there is help available." So I took it upon myself, as a mum of three, to say, "If I wanted to get help for my child where would I go, what would I do?" So I did a little bit of a review.

To me there are three big gaps: there is hardly anything local, it is not affordable and it is not specific. So locally in the affordable options we have Child and Adolescent Mental Health Service. If someone rings up to access that they are going to come down to Maitland. We cover the Upper Hunter Shire Council area and the Muswellbrook Shire Council area. You will have people from Murrurundi and Merriwa that are going to have to travel a three to four hour round trip to come down and get assessed and then they may not even get the appointment in Muswellbrook which is available. When I spoke to them they did say they will not take behavioural issues. I did not ask for elaboration on that. Considering that most mental health disorders are comorbid I thought that was pretty interesting.

Then we also had two other affordable options in town: we have social workers who have told me they are swamped, they are under the thumb, and they are not a long term option. When you are seeking treatment for someone that has mental health issues you know it is long term. There is one counsellor. When I say counsellor, I found it really hard as a layperson to understand what is the difference between a psychologist and a social worker? There has to be a difference, they are different titles, but no-one gives me a direct response, I still do not know. That one counsellor is out of the office of Upper Hunter Community Services four days a week. I have not got to private yet. I am scared because I started this research in October. There are three private psychologists in Upper Hunter and Muswellbrook shire councils. One only takes people over 18. So, there are two that will take children and adolescents.

They are both generalist psychologists and their books are closed until next year. If you have someone who is in crisis who are they going to see locally? There are clinical psychs, there is no child or youth specialist in that area. As a parent just trying to find information where would I go? I am not sick, my child is not sick and my brain functions, I think. I found it really tough to get the information, to find the pathways, who is going to help me, how are they going to help me, how long is it going to take? Eight weeks, what a joke. When I did ask those psychologists, "How long usually?" "It is usually about four weeks." So what are we going to give the parent who is holding their child's hand, who already feels helpless? Four weeks.

The Hon. GREG DONNELLY: Have you heard of a directory produced by area health up here that provides all this information?

Ms GEERIN: I did, I went through their directory.

The Hon. GREG DONNELLY: Was that helpful?

Ms GEERIN: No.

The Hon. GREG DONNELLY: Why not? Just be honest.

Ms GEERIN: When I first rang around or emailed—because I have three little kids so email is my preferred method—I found people would not give me direct answers until I said, "I'm from Where There's a Will." I did not think the information would be censored, I did not think it would be a big issue for me to go, "I want to know what services are available for children and youth".

The Hon. GREG DONNELLY: Fair question.

The CHAIR: I thank headspace for attending. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

Ms SCOTT: Yes.

The CHAIR: I think there will be more questions for you.

(Ms Scott and Mr Hirneth withdrew)

PAULINE CARRIGAN, Founder, Where There's a Will (Upper Hunter), on former oath

ANDREA BURNS, Secretary, Where There's a Will (Upper Hunter), on former oath

JACLYN GEERIN, Aberdeen Town Coordinator, Where There's a Will (Upper Hunter), on former oath

LISA WHITTAKER, Learning and Wellbeing Coordinator, Department of Education, affirmed and examined

SUE MACINDOE, Leader-Psychology Practice, Department of Education, affirmed and examined

DEBBORAH BECKWITH, Networked Specialist Centre Facilitator, Department of Education, affirmed and examined

The CHAIR: I welcome representatives from the Department of Education working in the Hunter region. Can you confirm you have been issued with the Committee's terms of reference and information about the Standing Orders of the length of the examination of witnesses?

Ms WHITTAKER: Yes.

The CHAIR: Would any of you like to make an opening statement before we begin with questions?

Ms WHITTAKER: No.

The Hon. CATHERINE CUSACK: Mrs Carrigan, thank you for your story. I do not want to upset you, but I have got no doubt you have saved lives with the work that you have done. I acknowledge your statement that suicide prevention is an intervention. Something we have not talked about is that the first point of contact young people make is with their peers, which I think is a blindingly obvious thing to say, but we are not acting on that information. I want my colleagues on the Committee to understand just how successful your initiative has been. Your story left your community aghast and disempowered and people wanted to know what to do, and you have empowered people. I wondered if you or your colleagues could talk us through what a difference it made to the community and how much support and case studies and lives that have been saved?

Mrs CARRIGAN: We will start to measure after Christmas. Time has been an issue with our volunteers. When I read the word stigma I call it "misuneducation". If I can compare it to slip, slop, slap, we did not know the sun was killing us and all of a sudden they told us about a mole that we could all look for. Guess what, mental health has the same moles. So, if you are trained to know what to look for in the first instance then this is true prevention. Maybe that is intervention once you have got the mole. Take it back. Do not get the mole in the first place because you see all the triggers coming. It is such common sense. We actually took our own program to the community. We started to explain this to them and it empowered them.

I actually could walk away right now and our community is not leaving this behind. We have a youth mental health program that when we first rolled it out we had to ask our friends to go to get them to sit on the chairs. You would get the occasional other person turning up. Now, when we put them up on Facebook they are shut down within two days. We can run them back to back over six days and have parents fighting to get into those rooms. We are now starting to roll it out in schools. What are we creating here? A common language. I would like to see the term "mental health first aid" taken off and called "mental health common language".

When parents are talking to their children across the table, or talking to their friends, or children are talking to their peers, they have to have a common language in which they can all speak. That does not exist at the moment. If you survey children and ask them if they would speak to the parents, they will say no. Why not? "Because they do not understand what I am talking about." I apologise that Pippa Baker is not here today. Pippa runs our Mental Health First Aid project. Pippa will talk to this extensively. Even in her own family, she had issues that children were not talking to one another and definitely not their parents, and it is an open conversation within their home now. She gives credit to Where There's a Will. While it is very difficult to talk about this, because there are privacy issues, we absolutely know that four youth, all males in the Upper Hunter, have been saved from suicide because of Where There's a Will and programs that were presented in schools.

The Hon. CATHERINE CUSACK: Was that because they felt able to reach out to adults who were empowered to know what to do?

Mrs CARRIGAN: Yes. On one occasion it was peers. On three occasions boys presented to adults; two were parents, one was a schoolteacher who was also a chaplain. We happen to know that that has happened within the last 12 months. It is very difficult to talk about because we cannot talk about privacy issues, but could be discussed, I imagine, under oath. They can be documented in some way.

The Hon. CATHERINE CUSACK: Feedback from schools here is amazing. Have interstate schools reached out as well?

Mrs CARRIGAN: Yes, and when you talk about Grafton and Lismore, everywhere. We do not know what we are going to do now with the knowledge we have on the ground. These schools, teachers and communities are reaching out to us and saying, "How can we implement this in our community? What do we have to do?" We are working along the lines of maybe holding workshops where we have PESA, Mental Health First Aid, advocate teachers and our treasurer and chairperson to explain how it all unfolded. We have a drawing of a jigsaw puzzle piece that started with Will's death and was added to. We still have massive holes, and one is services—and there will probably always be holes. We are not stupid: There is always going to be suicide and there is always going to be mental health. My problem with it is that if I knew then what I know now, my son would be alive. I will swear that under oath.

The CHAIR: My question is directed to representatives of the Department of Education. There seems to be no consistent approach once there has been a suicide attempt in a school. Should something be done at such a time?

Ms WHITTAKER: The department does have a document that supports schools after there has been a death by suicide. It is quite comprehensive and it is very structured. It is very supportive to the school at that very difficult time. In those guidelines there are particular timelines, so schools have an understanding of when certain things need to be completed. There are scripts to help the principal or other staff members speak to bereaved parents. There is also advice on what to do around supporting students. There is information to go out to students and also to staff and the community, things like newsletters and letters home to the families. That is a very supporting document for the school and for the community.

Ms BECKWITH: When that occurs there is notification to work health and safety and they respond as well, so if schools do not have that document for whatever reason, even though it is accessible to all public schools, they get a copy of that document so there is a consistent approach in schools.

Ms MACINDOE: The Department of Education has been working with headspace schools support. We have been rolling out support in different community areas. So schools might have a response plan that is ready and developed. It looks at developing a postvention support plan in a climate where it has not happened, so they have that material developed ahead of time.

Mr DAMIEN TUDEHOPE: You heard headspace give evidence earlier and saying the number of school counsellors is supposed to be six and it is only 3.2. Is that correct?

Ms MACINDOE: I do not know the answer to that question. 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.

Mr DAMIEN TUDEHOPE: If I were to take one of the powerful suggestions made by Where There's a Will it would be that the language surrounding mental health, self-harm and other issues that affect families and kids is so complicated that parents are intimidated by it and many kids do not know where to go. What is your response to that?

Ms MACINDOE: Are you asking about how we work with parents to understand what—

Mr DAMIEN TUDEHOPE: As a parent—and I have had personal experience in this—and I do not think for one minute that I am the least intelligent of individuals, but I am absolutely intimidated by the mental health industry. How do we make it easier?

Ms MACINDOE: That is something that hopefully will be an outcome of these kinds of hearings and the information you are seeking from people. Certainly, the Department of Education is working really closely with partners like Black Dog and LifeSpan. One of the key parts of LifeSpan is around how to work with our communities and parents to improve parents' ability to understand wellbeing, mental health and how to support their children.

Mrs CARRIGAN: Can I say something very quickly? I am going to throw that back to the Government. Most parents think it will never happen to them. Muswellbrook sadly lost a 12-year-old boy and headspace came over a few weeks. The parents did not attend, because it is not going to happen to their child when it has happened to that person's child. People have a total misunderstanding of the instigators and how easy it is to start to travel down the road of helplessness, how quickly it can happen. The big problem is that we have to convince parents that it actually is about them and their children, and then the Department of Education may stand a chance of engaging the parents. I know in our region our teachers try, and we are getting better at getting the parents there. Teachers have turned up, but not a lot parents have.

Mr DAMIEN TUDEHOPE: Some evidence we have heard was about the indicators that people would look for—things like truancy that is potentially an indicator of depression and potentially coming into contact with law enforcement agencies and alcohol and drug abuse, clearly. You have identified depression as potentially the biggest disease that will affect young people in the next 13 years. It is the education of parents on how to deal with that at an early intervention stage that is the greatest challenge for parents, is it not?

Mrs CARRIGAN: Yes.

Mr DAMIEN TUDEHOPE: If you have a child who refuses to get out of bed of the morning, are they just going through a phase or should I identify that they have a problem?

Mrs CARRIGAN: I say take it back to kindergarten and start a meaningful life for the child. You have to understand positive psychology education from preschool through to year 12 as a building block and a building block and a building block. But if a child is not getting out of bed and is truanting from school, I would not suggest that necessarily is a trigger; it could be just a behavioural problem.

Mr DAMIEN TUDEHOPE: That is the challenge.

Mrs CARRIGAN: That is the challenge. At the moment it is the challenge, but with re-education I think we have to go back to a preventative stage. It was our opening submission: What is prevention? I strongly believe—and I have been saying it for a long time—when the Department of Education sits here together with the primary health network, that is when the conversation may be beginning, but while ever they are sitting in separate rooms and having separate conversations, the word "prevention" means different things for the medical fraternity and education.

Ms GEERIN: I want to add that if we think about family as being the child's primary socialisation, we know that secondary socialisation is in education. So if we are going to prevent it, that socialisation has to happen in the house and it has to happen in the education setting.

Ms JODIE HARRISON: My question is to the department. I am aware of the various programs that are run in schools. My son, for example, is in year nine. He has just done a course in mental health that goes over two days. In that particular course there was a permission note that I had to sign. Firstly, why is it an opting in thing and, secondly, is there a plan by the department to ensure that parents understand the content of that so they can also have conversations with their children that will be helpful for prevention?

Ms WHITTAKER: I think that the school would encourage all students to participate in a course such as that, but it is so important to involve the parent in providing that permission because a parent would understand what is happening for that young person in their home at that time, and that may impact on them participating in that particular course. It also would give an opportunity to the parent, if there were any concerns, to go back to the school and discuss that with them. But, yes, information to parents about what the course is and why it is running is absolutely important.

Ms JODIE HARRISON: In that case, there was no information that came home to me as a parent.

Ms WHITTAKER: It was just a permission note around—

Ms JODIE HARRISON: It was a permission note that I signed for my son—and every other parent who chose to allow their child to receive this mental health support signed. There was no information that came back to parents to assist and have good conversations with the children.

Ms WHITTAKER: That is something that certainly could be provided. I do not know what course it was in particular, but giving parents information is a good thing.

Ms JODIE HARRISON: I just wonder why it is not automatically done. That is my question: Why is it not automatically done?

The CHAIR: It is a good point.

Mrs CARRIGAN: Can I just speak to the fact of what I see is a problem between Where There's a Will and the Department of Education, which is not a criticism; it is just because they did not see us coming when we first started up. There is a training organisation called the Principals Australia Institute. The government programs that are quite readily available are MindMatters and KidsMatter. At the moment the school has funding to maybe send one teacher off to be trained, two if they are lucky with their budgeting. So that is okay. They travel to Newcastle from the Upper Hunter. We went to this organisation and said, "Look, we are doing really well with our schools. We can put 30 or 40 of these in the room. Can we send one up?" "No, it doesn't work like that." "I know that, but I am saying can we send one up?" "No, Mrs Carrigan, you are missing

the point here. They come down." And I am saying, "Yes, but that is one car on the highway." That is one example of the difficulties.

You see, the plan exists. The wellbeing framework has been delivered to schools. The training sits over there. There are too many broken links between the wellbeing framework and the knowledge of the principal—let's say most principals are over the age of 50. "Here's the wellbeing framework. We want you to do that now." They do not even know what it is or what it entails. We were like vacuum cleaner salesmen going to schools and saying, "Wow! Have we got a deal for you!" We funded this journey. We brought in the support. Originally it was very hard. I had so many nights of tears and so many insults—and rightly so. Who am I to walk into these schools and start saying to them, "You're not doing enough?" That is why I always say try not to criticise but to encourage. We had one principal who virtually told me they were all over it. She now works for Where There's a Will as a retired principal and goes around and tells other schools, "Don't think you're doing anything, because you're not." It is a misunderstanding. It is such a mess that you have no idea. But everything exists. We just have to join the dots.

The Hon. CATHERINE CUSACK: Following that up, we have had so much evidence from government agencies that their policy is to build from the ground up in communities, to empower communities and to have capacity in families, and then we hear from an organisation that is doing exactly this. It is a struggle to understand why people like you are not just jumping all over it and expanding, because it is exactly what we say we want.

Ms MACINDOE: I think the department has in the last few years certainly started to focus on being more coordinated around responding to preventing youth suicide. There are a number of targeted programs that are new and are being delivered to schools, so there has been a commitment with employment of new head teacher wellbeing positions and a commitment to working with LifeSpan to implement Youth Aware of Mental Health [YAM], which may be the program that Ms Harrison's son attended—I do not know. It is a program for year nine students and it looks at encouraging help-seeking behaviour, supporting a friend and understanding what it is like to talk to a professional if you have a mental health issue. There has been a commitment to implementing new initiatives and working in partnerships—and certainly working in partnerships with local communities. No two schools are alike. All schools are a reflection of the community they are in, so a wellbeing plan within a school is going to be tailored for that school and needs to respond to that community.

Mr MICHAEL JOHNSEN: What is the department's view towards the Positive Education Schools Association or PESA?

Ms WHITTAKER: I could not comment on that. I would have to take that on notice, unless another—

Ms MACINDOE: No. What was the acronym again? I did not hear it.

Mr MICHAEL JOHNSEN: PESA. You do not know anything about it?

The CHAIR: Okay.

Mr MICHAEL JOHNSEN: That is probably sufficient. Thank you.

The CHAIR: My question is probably to Where There's a Will. In your submission you talk about having some kind of national awareness campaign. I think that has a lot of merit to it. When we have been organising our visits, we have been concerned about the fact that the more we talk about suicide, it could be more likely to happen in various communities. If we were to put out a campaign, do you have a fear that that would encourage suicide?

Mrs CARRIGAN: No, because the campaign is not about suicide. The campaign is about everything other than. It is about building families, talking to one another, talking about the tough stuff—the tough stuff does not have to be suicide—turning and talking to your friends about the tough stuff. Everyone thinks suicide happened yesterday. It was a build-up over many years of little things. I often say wonderful things are being done in the world of anxiety. I challenge you to walk up to a year 8 person and say to them "What's anxiety?" You have got it on posters and you have got it on the web. You can go over there and talk to him about anxiety. They are all going to stand over there and say, "What in the bloody hell is anxiety?" Unless you train them in the verbal terminology of the feeling that they are having and the difficulties, they will never seek help. They will never even discuss it with their friends.

Ms GEERIN: You asked Mrs Carrigan earlier about doing mental health first aid training. Parents have said to me that their children have suffered from anxiety and they have gone on the course. They go, "Yes, I do have those symptoms. That is what it is", and then they go back and talk to their parents about it. Because I have been a coordinator, we had 30 people give up two days to do the first-aid training. It was amazing how

many after the first day went home and could speak to their children about things such as, "You do need to move physically and sometimes your diet can affect how you feel, can't it? Those simple questions. The conversation does not have to be so difficult. I have noticed that so many people have said to me that it is that simple language that we give them, those little bits of help that are common sense if you are not going through it that have made a big difference.

The Hon. PAUL GREEN: There is a stigma with mental health, especially with their peers and the most important opinion of teenagers is their peers. The last thing they want is to be known that they have a mental health problem. You are saying that they must get away from that; that this is a life issue. It has to have a different title. There is a mental health stigma. This is life. You have anxiety when you are a child, you have anxiety all the way along life, so these are life skills. You will have feel down, you will have bad days and it could be because it is dietary or because you are not exercising. It is mental health but it is actually life, isn't it?

Mrs CARRIGAN: It very much is life. Parents do not know that a lack of sleep—and I will hone in on one topic so you get the picture. They are doing the HSC, they are 18 and they are drinking a little bit on the side. They are not sleeping properly. They are using social media until two o'clock in the morning—time bomb ticking. I am not saying that if there are 30 in the class that the whole 30 may commit suicide but, bloody hell, one of them might because these parents don't know. I am telling you now I lost a son because I did not know the basics—the very basics, and he was an extremely successful young man; he was an extremely successful sportsman. He was taken out of his sport for the first time ever. He did not have sport. He had just taken on his own business. He had a mortgage; he was very popular. He was a new electrician—"Get Will, get Will". We knew. He told me.

I know now through Mental Health Australia—the last time I saw him he told me—he said, "Mum, I can't do this anymore.” I went for the fist pump. I said, "Mate, you're so successful. You're going on holidays next week. You'll be fine." He was dead that night because I didn't hear what he told me. I know now. If one other kid says that to me now, I am going to say, "Come here, buddy. What do you mean? How deep? Do you mean you just can't get through the day?" I have seen how simple it is in our area to do this. I would hate to be sitting in government and saying, "How are we going to take what they're doing and replicate it?" And we have no answers for that.

The Hon. PAUL GREEN: That is my whole point about this triage thing; you just nailed it. There was nothing extraordinary about what you just faced. I have six kids; I have heard those things and you can just run over it; it is that simple but it is a cry for help. I am struggling.

Mrs CARRIGAN: Yes, and he had cried out to more than me in the last week of his life, and it was just that type of cry and not one of us heard it. And there is another thing: everyone says everything is good in hindsight. I am not calling what I know about this now hindsight. That is wrong. I am calling this education. That is what we have to do.

The CHAIR: Mrs Carrigan, thank you so much for sharing your personal story with us. It is really valuable for us to hear but I know it is incredibly hard for you to share, so thank you.

Mrs CARRIGAN: I thank you for taking the time to listen to me today because I have this in me and I think I am actually going to have a really nice rest now.

The CHAIR: I hope so. I thank you all for appearing before the Committee today. The Committee may wish to send you some additional questions in writing, the replies to which will form part of your evidence and be made public. Would you be happy to provide a written reply to any further questions?

Ms BURNS: Yes, of course.

Mrs CARRIGAN: Yes.

Ms GEERIN: Yes.

Ms WHITTAKER: Yes.

Ms MACINDOE: Yes.

Ms BECKWITH: Yes.

The CHAIR: Thank you all. That concludes our public hearing. I place on record my thanks to all the witnesses throughout the day and members of the public who have shown an interest in attending the Committee's hearing. I thank the Committee members and staff for organising this visit. It was incredibly valuable. I thank Hansard also for giving up their time and working so hard. It is incredibly demanding to do an entire public hearing so thank you for your time and effort today and over the weekend.

(The witnesses withdrew)

The Committee adjourned at 13:10.