REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PREVENTION OF YOUTH SUICIDE IN NEW SOUTH WALES

At Preston-Stanley Room, Sydney on Monday, 12 February 2018

The Committee met at 9:30 am

PRESENT

Mr Damien Tudehope (Acting Chair)

The Hon. Greg Donnelly
The Hon. Paul Green
Ms Jodie Harrison
Mr Michael Johnsen

ANNA BUTLER, Manager, Domestic Violence Death Review Team, NSW Coroner, affirmed and examined

The ACTING CHAIR: I declare the hearing open. This is the second public hearing of the Committee's current inquiry into the prevention of youth suicide. Last November the Committee heard from a wide range of people working to prevent youth suicide in the Hunter region and across the country. Today we will be hearing from other stakeholders, including the New South Wales Child Death Review Team, NSW Coroner and the Australian Bureau of Statistics. We will also hear from the Advocate for Children and Young People, both National and New South Wales Mental Health Commissions, Orygen and Reach Out.

As the Committee has mentioned on the previous occasions, this is an important but sensitive subject and an issue which may affect people in the room personally. The Committee is very aware of this. I encourage you to contact Lifeline on 131114, or Kids Helpline on 1800551800 if you or somebody you know needs help. I ask everyone to turn off or turn to silent your mobile phones. Ms Butler, can you 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?

Ms BUTLER: Yes, I have.

The ACTING CHAIR: As is our practice we invite people to make an opening statement if they like. Would you like to make an opening statement?

Ms BUTLER: I would. I acknowledge the traditional custodians of the land on which we meet today and pay my respects to elders, past, present and emerging. I commend the Committee for holding this important inquiry and extend my thanks for the opportunity to appear today. The Acting State Coroner has asked that I extend her apologies for not being here, however she is currently in an inquest in regional New South Wales. I would also like to acknowledge the tireless work of those from the public and private sector engaged in suicide intervention and prevention across the country. While it is, of course, challenging to measure prevention, it is undeniable that their sustained efforts help to stem this tragic loss of life. Since its establishment in 2011, I have managed the NSW Domestic Violence Death Review Team, a multi-disciplinary review body, established under the Coroners Act and convened by the NSW State Coroner.

The team undertakes quantitative and qualitative analyses of domestic violence related deaths and synthesises this information to develop findings and recommendations that seek to improve the response to domestic violence in our community, and thereby reduce the likelihood of these types of deaths. In 2017 the team's secretariat, which consists of myself and research analyst Emma Buxton, also commenced an additional function of assisting Coroners on open cases and providing specialist expertise in respect of domestic and family violence in coronial matters. In establishing the team, the New South Wales Government recognised that systemic death reviews can yield important learnings not otherwise ventilated through criminal justice or coronial processes, revealing insights into people's lived experiences and identifying missed opportunities for intervention and prevention—those points in a person's life course where the story could have changed.

To date my team's work has primarily focused on domestic violence related homicides and we have developed a sophisticated and highly nuanced, whole of population homicide dataset, which allows for disaggregated data analysis across a broad range of variables. However, in a departure from our usual homicide focus, the team recently piloted a six-month whole of population investigation into domestic violence as a feature in completed suicides, the findings of which are set out in our 2017 report tabled in Parliament, and I have a number of copies of that report for the Committee. I appear today not as an expert in suicide per se but rather as someone with experience in working with data in a coronial context who can speak to some of the current limitations and challenges concerning suicide data collection and analysis.

I will also propose a potential opportunity to overcome some of these limitations, namely the establishment of a specialist suicide mortality review body in New South Wales. There are over 6,000 deaths reported to the NSW Coroners Court annually. Suicides make up over 10 per cent of those deaths and current figures for New South Wales stand at around 700 suicide deaths each year. Every suspected or apparent suicide is investigated by the NSW Police and a brief of evidence is prepared and submitted to the court. The vast majority of these matters are dispensed with by the court, meaning that they do not proceed to inquest as the identity of the deceased and the date, place, cause and manner of death is sufficiently disclosed by the evidence before the court. In particular circumstances, the legislation mandates that an inquest be held and this includes suicides that occur in custody or in the course of a police operation.

An inquest may also be held into an apparent suicide if the court considers that there is a public interest in investigating and ventilating issues arising in a particular case, however I note that these are few in number in New South Wales. The Act requires coroners to give reasons for dispensing with a matter. However, because of the court's current legislative framework and limited resources these reasons generally consist of one or two paragraphs setting out the circumstances surrounding the death and a finding as to the manner of death. This can be contrasted with other coronial jurisdictions where comprehensive non-inquest or chamber findings are regularly published in suicide cases that do not proceed to inquest. The coronial jurisdiction is a rich repository of information and the current practice in New South Wales in my view represents a missed opportunity to gain greater insight into the context and circumstances of these deaths.

As with all deaths reported to the court, suicide deaths are captured in the National Coronial Information System [NCIS]. NCIS codes for a broad range of data variables and for New South Wales this information is primarily derived from the police report of death to the coroner, the p79A form, autopsy and toxicology reports, and the coroner's determination as to manner of death. Again, resourcing issues for the court mean that the quality and timeliness of New South Wales data on NCIS is compromised, which of course has a flow on effect to other suicide datasets that derive their data from NCIS. I say this not to denigrate either the NCIS data system or those people that are coding to it, but rather to highlight that this is a process that relies on human resources to operate effectively and the limitation of such resources continues to be a challenge for the court.

Putting aside these specific challenges for the moment, the court acknowledges that the NCIS dataset is important in establishing broad prevalence and demographic suicide data—the who, what, where and how of suicide. However, analysis of aggregated data on broad demographics provides little insight into the nature and scope of intervention required to prevent future deaths. This information only becomes available with a deeper, more qualitative analysis of various information sources and other research activities—the kind of work my team undertakes in relation to domestic violence related deaths, work that I submit provides a legislative and operational framework that would readily translate to suicide review.

As the work of my team demonstrates, the death review process acts as a lens into systems and affords a critical and impartial analysis of the effectiveness of those systems—where improvements need to be made or where services do not reach. This process enhances our understanding of systemic issues both within individual cases and when looking across cases collectively. It provides critical insights that guide system reform and the development of targeted prevention initiatives. Put simply, to learn from a person's death you have to investigate, seek to understand and critically examine the person's life—their intersection with systems and services, their engagement with community and other support networks and their help seeking behaviours.

While this kind of qualitative analysis of suicide deaths is undertaken by other agencies with respect to particular cohorts, for example the Child Death Review Team), the work of my team demonstrates the strength of whole of population surveillance, which allows for the development of robust and nuanced data collection as well as in-depth case analysis. A further strength of my team is the ability to collaborate and share information with death reviews in other jurisdictions, under the auspice of the Australian Domestic and Family Violence Death Review Network. To date, key achievements of the national network include the development of National Data Collection and Data Sharing protocols which have facilitated the establishment of a national minimum dataset and so for the first time in Australia, there now exists a capability to accurately and meaningfully report national findings on domestic and family violence related deaths.

The development of an appropriately resourced and appropriately empowered suicide review team in this State would similarly facilitate inter-jurisdictional information sharing with the existing suicide review processes that are operating in the other states and territories. This would contribute to the development of enhanced national reporting of suicide data. The need for which has been identified in number of written submissions before the Committee. Many agencies and people are already working to achieve reduced suicide rates, however, as this inquiry recognises, there is more work to be done. So, while this is a proposal that clearly requires further development in collaboration with the various government and non-government agencies in this space, I submit to the Committee that establishing a multi-disciplinary suicide mortality review body, would provide a strong central point for coordination and analysis of quantitative and qualitative suicide data, and this would be a significant contribution to the intervention and prevention of suicide deaths in New South Wales.

The ACTING CHAIR: That is very comprehensive; thank you very much.

The Hon. PAUL GREEN: In the light of what you have said I have a couple of questions. Why do we not have one, given the fact that youth suicide is increasing, especially in females? Why don't we have one and what would it look like?

Ms BUTLER: I cannot answer the question as to why we do not have one. I was surprised—

The Hon. PAUL GREEN: Has it ever been recommended?

Ms BUTLER: There has certainly been work done to progress the development of a suicide register in New South Wales. We were engaged in some very preliminary and, essentially, informal conversations with the Mental Health Commission around there being no suicide register. I was really only alerted when we started to look at the domestic violence related suicides. I had assumed that there was a suicide register. It soon became apparent that there was no such register. I cannot answer the question as to why not but it is certainly an issue that has been identified by various agencies. Whether or not that has progressed I cannot say.

In terms of what it would look like, I think, you would look at the learnings and experiences from the domestic violence review team. It could look, in form, I guess, much the same. It is all about having the right people sitting around the table. So, in the development of the case review processes and case identification processes that needs to be informed by a whole range of stakeholders. So the first point would be working out who needs to be sitting around the table. Another key element—and we have looked quite a bit at what is the best practice principles—

The Hon. PAUL GREEN: Who does have best practice around Australia?

Ms BUTLER: In terms of suicide review?

The Hon. PAUL GREEN: In terms of the multi-team approach and the review?

Ms BUTLER: I think the example of the Coroners Prevention Unit in Victoria is an excellent model to follow. That is a specialist unit that sits within the Coroners Court of Victoria and assists coroners in their cases. They have the capacity to review a whole range of reportable deaths. Their family violence review team sits within that unit. That is also where their suicide register sits. They look at medical-related deaths and accidents. Their scope is very wide in terms of the reportable deaths that that unit can review. In my view that is an excellent model in terms of that sort of review process.

The ACTING CHAIR: How many people are part of your team? Two?

Ms BUTLER: In terms of our day to day work it is two—Emma Buxton and me. The team itself has 16 statutorily appointed members—government and non-government.

The ACTING CHAIR: So there are only the two full-time members attached to the Coroner's Office.

Ms BUTLER: Correct; yes. That is not really enough, I should say. I am not sure that that should be put forward as a standard—

The ACTING CHAIR: That is okay; it is on the record now.

Ms BUTLER: We are a two-person team.

The ACTING CHAIR: What is the average time between the passing of someone and the time in which a finding is made? You made a criticism of the reliability of data because of the time taken to get to a formal finding. What is that time?

Ms BUTLER: It is really variable, I think. Where matters or suicides are dispensed with—if there is nothing complicated in terms of the police and their role in preparing a brief of evidence—it is usually within 12 months. It is variable. We have a lot of open cases, still, in New South Wales. I would need to take that question on notice to give a more definitive answer.

The ACTING CHAIR: You would need to take that on notice to give an average time.

Ms BUTLER: Yes, because it is variable.

The ACTING CHAIR: What are the factors which inhibit the quicker delivery of information to the Coroner's Court?

Ms BUTLER: I think it is just capacity of the various agencies. Are you talking about the delivery of—

The ACTING CHAIR: If there is a police report compiled in respect of a matter and it is referred to the Coroner, what are the factors which are delaying the finalisation of the matter, whether it is domestic violence or some other matter?

Ms BUTLER: For the more straightforward matters I think it is just a question of the caseload—the capacity of the court to process matters. Again, I am not really engaged in the specific mechanics of that aspect of the Coroner's Court. My understanding is that there are capacity issues in terms of getting through the caseload. So, where a focus is on getting matters closed—it is a valid focus to finalise matters—something has

to give. There has to be a compromise, and that is what I was referring when I said that the capacity for a Coroner to give more detailed reasons for dispensing with a matter is limited when there is a huge caseload and the emphasis is on getting matters closed. The capacity to take a moment to do a more detailed review just does not exist in the court.

The ACTING CHAIR: How would we fix that? Is it just a personnel issue?

Ms BUTLER: Developing a review team of the kind I have suggested would address some of those issues, because the review team would take over that function, essentially. The Coroner would continue to make findings in terms of identity of the deceased. That is a legislative criteria that needs to be fulfilled for the Coroner to dispense with a matter and finalise it. But that would then be handed over to a specialist team that can undertake the review process.

The ACTING CHAIR: Would you see any benefit in having a specialised Coroner who would deal with coronial matters in respect of suicide generally or in respect of youth suicide, where that person would have the expertise or the background in relation to this, which was tailored to a more streamlined resolution of matters?

Ms BUTLER: I would have to think about that. A specialist Coroner is an interesting idea. I probably could not say anything beyond that. I suppose the challenge there is that the number of matters that go to inquest, in terms of suicide, will continue to be very small if you did have a specialist Coroner in their case management of the suicide matters. The opportunity for those learnings and to be looking at cases individually and then across cases, which is the way processes operate, it is still going to be limited even with the specialist Coroner looking at suicides.

The ACTING CHAIR: You identified an opportunity for a specialist suicide prevention review team, which I have some sympathy for. If in fact that was informing a specialist Coroner, maybe it will have a more focused view on how we deliver prevention opportunities.

Ms BUTLER: I think that is an interesting idea. As I said, it is not one I can speak to in any detail but I would certainly be interested to hear the views of the chief magistrate about that.

The ACTING CHAIR: We have a former Coroner, Mr Barnes, who is coming today. I will ask him about it.

Ms BUTLER: Yes.

Ms JODIE HARRISON: Thank you for coming along today and giving us your verbal submission. You mentioned that there are 700 suicide deaths each year. Inquests are only held on inquests for certain reasons, such as death in custody—

Ms BUTLER: Mandated inquests, yes.

Ms JODIE HARRISON: How many inquests on suicide deaths were held last year, for example, and would the review team that you are suggesting review all suicide deaths?

Ms BUTLER: In respect of your first question as to how many, I cannot tell you the answer to that. I did ask the court chief executive officer but the court does not retain any data that can be readily examined in respect of number of inquests and suicide inquests. There is no information captured in that way in the court. In respect of looking at every suicide, I would assume an approach that is similar to what the Domestic Violence Death Review Team does would help. From a homicide perspective, we look at every death and then we do reviews of those where we have identified a domestic violence context. Because you are talking about much more vast numbers with a suicide review you could not do a review into every case.

Having a whole-of-population surveillance would allow you to identify groups of cases that you could then do a focused analysis on. For example, you could do a focused analysis on the suicides of young people, or people from a particular area, or a particular method of suicide. So once you have that whole-of-population data set, you can then start to drill down on those cases where you think there would be the most value in respect of your in-depth review. The interesting thing is having a whole-of-population surveillance for the purposes of developing your data set would allow you to start to get a snapshot of each case for that surveillance process. Certainly the experience of the Domestic Violence Death Review Team is that as your expertise in doing those types of reviews continue to develop, you see the issues that might not at first glance jump out. You start to see similarities in cross-cases, so I think once you conduct that whole-of-population surveillance there are areas you can then drill down and review that initially you might not have thought would be a focus area.

Ms JODIE HARRISON: I was wondering whether the Coroner has any views on gaps with agencies—acknowledging there is no suicide mortality review team at the moment—and whether there are any failures in the systems?

Ms BUTLER: I am not in a position to speak to that issue. That is not something that is in my scope of knowledge.

The Hon. GREG DONNELLY: With respect to the collection of data on suicides in New South Wales by the Coroner, is there a document or reference that we can go to which gives an explanation of the history in New South Wales with respect to the way in which the Coroner has dealt with suicides?

Ms BUTLER: Not that I am aware of.

The ACTING CHAIR: Michael Barnes was the Chief New South Wales Coroner. He is now the Ombudsman. I am sure he will be able to help.

The Hon. GREG DONNELLY: Having taken over the role that you are in now, you obviously have done a little bit of looking back at the way in which suicides have been recorded in New South Wales?

Ms BUTLER: My experience is derived from the work that we did last year compiling a six-month whole-of-population dataset for the purposes of the Domestic Violence Death Review Team, so we undertook an analysis of every—well, as far as we could identify—suicide that occurred in New South Wales in a six-month period. We looked at each one to work out whether there was a recorded history of domestic violence. That was the methodology and that was the team's first foray, I suppose, into suicide and the data collection within the court.

The Hon. GREG DONNELLY: I found the evidence you provided this morning surprising. That is not a reflection on you, but obviously there have been suicides in New South Wales since it was a colony.

Ms BUTLER: Yes.

The Hon. GREG DONNELLY: What I am trying to grasp is how the Coroner over that time dealt with suicide. In some sense, I am trying to understand what has been done up to this point. I think it is important because of the whole history in which suicides have been dealt with by the Coroner and understanding that is important, particularly to create a basis upon which to look ahead and see how some of the propositions you put to us this morning might fit in.

Ms BUTLER: In that sense, I am a newcomer to the jurisdiction. Predating the National Coronial Information System, I do not know what the data collection looked like.

The Hon. GREG DONNELLY: That is fine. In respect of the scope of your responsibility and the scope of your expertise, are there jurisdictions overseas that have come to your attention which, with respect to the implementation and maintenance of detailed information about suicides, they do it particularly well?

Ms BUTLER: Yes, there has been a lot of work done in New Zealand over the past couple of years. Their family violence death review sits within their Health Quality and Safety Commission. More recently, they have developed a suicide mortality review, so they did a lot of background work in respect of feasibility studies and cost-benefit analysis and have since piloted their suicide mortality review, which I believe is now a permanent review function. I can make those reports available to the Committee. They are very, very detailed.

The Hon. GREG DONNELLY: With respect to this inquiry, we are looking at the matter of youth suicide.

Ms BUTLER: Yes.

The Hon. GREG DONNELLY: As a result of the work you have done with the Coroner's office, are there any particular reflections, suggestions or thoughts you want to put to us to consider in respect of the sole issue of youth suicide and how it is in fact recorded and maintained and how that information is used over time?

Ms BUTLER: In the six months of the suicides that we looked at for the purposes of our study, there were six people who were under 18—three girls and three boys. I guess what is telling is how little I am able to tell you, other than that raw number. That is the level of information that exists in the courts. It is more an absence of information and an absence of focus.

The Hon. GREG DONNELLY: Respecting anonymity and the obligations that exist, do you say you cannot tell the Committee about the cause of the suicides?

Ms BUTLER: I could tell you the demographics—the basics. We then looked at it with a particular focus seeing whether or not there was a recorded history of domestic violence. This was a particular focus and

very much a first-stage review. I guess I mean more generally, in terms of there being that kind of review and that sort of level of oversight, it is just not happening from the Coroner's Court perspective.

The Hon. GREG DONNELLY: I refer to the domain of youth suicide which is obviously the issue of self-harm which may in and of itself not lead to suicide, but there has obviously been an attempt to harm perhaps leading to the intention of suicide. If there is a death and it goes to the Coroner where would that information be captured?

Ms BUTLER: Once there is a completed suicide? Do you mean that sort of historical information of prior attempts or prior self-harming behaviours?

The Hon. GREG DONNELLY: Yes.

Ms BUTLER: With the homicide cases we review the medical information. We have strong powers to call for information from all non-government and government agencies. We will call for information if it is not otherwise in the brief. We do find that sort of information—

The Hon. GREG DONNELLY: It could be captured in health records at a hospital?

Ms BUTLER: Yes, or it might be education records, child protection records or police. It is about that sort of information and part of the problem is that it sits scattered across the agencies. I guess that one of the benefits of the death review is having that oversight across all of those agencies that might hold little pieces of information that you can then draw together to better understand that one case, and then you can look across the cases to get the big picture. Those are the kinds of things that you would be able to access, provided that information exists either in formal records—so health, school, whatever—or from statements from friends and families. When we are constructing our reviews we rely heavily on the statements of friends and families and that pick up gets incorporated into the narrative that we construct for our cases. Similarly, you would be able to do that with the suicide review—drawing together either recorded information, the formal record, and anecdotal information. It is not before a court in that sense so it is not subject to the rules of evidence in that same way, so you can draw together information from wherever you can derive that information.

The ACTING CHAIR: You have identified six suicides in circumstances where there is a correlation with domestic violence?

Ms BUTLER: No, this was just six in that six-month period.

The ACTING CHAIR: That is right; in that six-month period where there was a correlation with domestic violence?

Ms BUTLER: No, there were 330 suicides in that six-month period and then there was a focus subset that had a recorded history of domestic violence. As I said, it is a very specific and first stage attempt at looking at domestic violence as a characteristic. So those six formed part of the whole population dataset of suicides in a six-month period.

The ACTING CHAIR: There had been, not so much a correlation, but there had been incidents of domestic violence in those six cases. What am I missing?

Ms BUTLER: Not necessarily with those six. There were 330 suicides. Of those I think 85 males had a recorded history of domestic violence.

The ACTING CHAIR: Yes. So of the 85 six were young people?

Ms BUTLER: No, of the 330, six were young people.

The ACTING CHAIR: But there was some history of domestic violence in relation to those six?

Ms BUTLER: Not necessarily. I think we are at cross-purposes. It is 330 deaths in total, of which six were young people. Then we did a focus running those 330 cases through the CoPS data system. There were 330 suicides, 39 per cent of females and 38 per cent of males who had a recorded history of domestic violence. It might need some more talking through. It was a very specific focus.

The ACTING CHAIR: How many of those were young people?

Ms BUTLER: I would need to go back and check in terms of that subset that were known for domestic violence. I would need to recheck my data in terms of how many of those six, whether or not they formed part of the more specific cohort that were known for domestic violence. I am not sure.

The ACTING CHAIR: In the six-month period you identified six young people who had taken their lives by suicide?

Ms BUTLER: Yes.

The ACTING CHAIR: You have no information about whether those six had a link with domestic violence?

Ms BUTLER: I would need to check it. I will take that question on notice. I could certainly give you more detail about that in terms of those six within that 330.

The ACTING CHAIR: I am sorry.

Ms JODIE HARRISON: That was my question.

The ACTING CHAIR: Part of your review is to look at a cross-section of the availability of services.

Ms BUTLER: Yes.

The ACTING CHAIR: And how it might have been prevented, vis-à-vis domestic violence.

Ms BUTLER: Sure.

The ACTING CHAIR: Did you review any of those specific cases to say, "There are gaps in the system which might have been addressed"? In circumstances where there is a domestic violence incident do you identify opportunities for increased services or services which should be available to young people in that circumstance?

Ms BUTLER: Absolutely. That is the focus of our review and that is the way we approach our homicide cases. This was very much just a pilot study thinking about how we were going to look at domestic violence as a characteristic of completed suicides. It is very much just a first phase, having a bit of a go at it, to be honest. It had always been anticipated that we would look at domestic violence related suicide but with nothing beyond that in terms of that sort of guidance. This was a just a first foray into this type of review where we took a whole population of six months. We limited the ones that we looked at a little closer, really in terms of a kind of broader demographic approach to those that had a recorded history on CoPS. We looked at histories of apprehended violence orders, whether they are victim status, perpetrator status, or both. Those were some of the variables that we focused on very much just as a first stage.

The ACTING CHAIR: It may be something for study further on. Is a young person who is exposed to domestic violence more at risk in relation to suicide?

Ms BUTLER: I cannot definitively answer that. We cannot say what is causal in terms of the research that we have done around domestic violence as a feature. I cannot say that because this person experienced domestic violence that is why they chose to kill themselves.

The ACTING CHAIR: Is it a risk factor?

Ms BUTLER: I cannot speak to that in terms of the work that we have done in this space at this stage with a two-person team.

The ACTING CHAIR: It might be that potentially we are not taking enough care of young people. We certainly focus on the victims and the perpetrators. Are we taking enough care of the extended network of people who are potentially impacted by domestic violence incidents?

Ms BUTLER: Probably not, I would say. In terms of identifying intervention points, what you can say is that, okay, this is a child who, for example, is experiencing domestic violence [DV]. That becomes a point where there should be a holistic response, wraparound care and services acting together to support that child experiencing DV. Does that happen? Sometimes. Does it not happen? Probably more often than not. Where that fits in terms of a risk factor I cannot say. Our focus is not so much on trying to construct a tick box of risk factors but to look at opportunities for intervention. Where we can say, for example—and again I am drawing on my knowledge of homicide cases because that is where the bulk of our work is being done—that we know that people are continuing to see their general practitioners [GPs] and are making disclosures, or you say that you know that children are attending school and you identify those as potential intervention points that may not be exploited as much as they should be.

The ACTING CHAIR: Maybe this is something that a suicide prevention review team would focus on.

Ms BUTLER: Absolutely, absolutely—which hopefully would have more than two people.

The ACTING CHAIR: I think you have made that point.

The Hon. GREG DONNELLY: You just have to come to work a bit earlier. That is all you have to do.

The ACTING CHAIR: Get to work earlier, is it?

The Hon. GREG DONNELLY: Yes. Work through your lunch break!

Ms BUTLER: We get there very early.

The Hon. GREG DONNELLY: With respect to the National Coronial Information System, which Commonwealth department manages that? Do you know that?

Ms BUTLER: Financially, it comes from all the States and Territories and Commonwealth. They sit within forensic medicine in Victoria but I think it is shared governance across States and Territories. There is a board that has representative members from each of the different States and Territories.

The Hon. GREG DONNELLY: Where do we go, or what is the basis upon which information regarding a suicide attracts reference to the system? Is there a piece of legislation or regulation that lays out which cases are referred from New South Wales? Have you reported in that system?

Ms BUTLER: That information would not sit within NCIS—is that what you mean?

The Hon. GREG DONNELLY: What is the basis for the New South Wales Coroner to be referring information up to be reported on the system?

The ACTING CHAIR: For example, does it appear in the annual report?

Ms BUTLER: It is not a system that works in that way with those sort of qualitative findings. It is very much quantitative. It is very detailed in terms of its quantitative information capture, but if you are wanting to look at qualitative issues, which is what I understand you are sort of getting to in terms of service interaction in those cases, that is not going—

The Hon. GREG DONNELLY: Let me put it another way. Does the National Colonial Information System capture its own information that is quite independent from the Coroner?

Ms BUTLER: No. That information feeds in from the Coroner's Court. They then do quality assurance checks and things that go on at their end. The process is that once a matter is finalised in the Coroner's Court, that gets fed in from the New South Wales court staff—they are coding into NCIS—and that then sits within the NCIS broader dataset of all of the jurisdictions.

The Hon. GREG DONNELLY: Finally, with respect to coroners from around Australia in the different States on this issue of suicide—and if you do not know the answer to this, please just say so.

Ms BUTLER: Sure.

The Hon. GREG DONNELLY: Is there discussion going on among the coroners about this issue of reporting information and better analysis of, dare I say, suicide matters and, specifically, youth suicide matters?

Ms BUTLER: I do not know a lot about this area, but I understand that this is some of the work that Suicide Prevention Australia has been working on with its National Committee for Standardised Reporting. As I understand it, that has representation from each of the coroners' courts that are on that committee. I guess that has been a focus on working towards the development of a national minimum data set for suicide collection so that everyone's data will talk to each other. But beyond that, in terms of what the other focus of that committee is, I cannot speak to that.

The ACTING CHAIR: I think they are all the questions we have for you. Thank you for attending today. If we have any further questions that we want to send you, are you happy to answer those?

Ms BUTLER: Sure, of course.

The ACTING CHAIR: Thank you for being here and appearing before the Committee today. We look forward to hearing from you. You may like to take on notice that issue of a specialist coroner.

Ms BUTLER: Yes, all right. I will.

The ACTING CHAIR: Thank you.

Ms BUTLER: Thank you.

(The witness withdrew)

JAMES EYNSTONE-HINKINS, Director, Health and Vital Statistics Section, Australian Bureau of Statistics, affirmed and examined

JUSTINE LOUISE BOLAND, Program Manager—Health and Disability Branch, Australian Bureau of Statistics, affirmed and examined

The ACTING CHAIR: The Committee welcomes representatives from the Australian Bureau of Statistics. Thank you for appearing before the Committee on Children and Young People. The Chair of the Committee, Melanie Gibbons, is unable to be present today so I am conducting the hearing. Have you received the pro forma pack in relation to giving evidence before this Committee and the standing orders that relate to giving evidence?

Mr EYNSTONE-HINKINS: Yes.

Ms BOLAND: Yes.

The ACTING CHAIR: As part of our process, please state the capacity in which you are giving evidence before the Committee today.

Ms BOLAND: I am the program manager of the Health and Disability Branch within the Australian Bureau of Statistics.

Mr EYNSTONE-HINKINS: I am the Director of Health and Vital Statistics at the Australian Bureau of Statistics. We look after deaths and causes of death data.

The ACTING CHAIR: Our process normally is that we invite people, before they give evidence or answer questions, to make an opening statement in relation to the issue the Committee is examining. Would you like to make an opening statement?

Ms BOLAND: Yes, thank you.

The ACTING CHAIR: Will both of you make a statement, or just one of you?

Ms BOLAND: Yes.

The ACTING CHAIR: That is okay.

Ms BOLAND: I will begin and then throw to James.

The ACTING CHAIR: That is all good.

Ms BOLAND: Thank you. As I said, I lead the Health and Disability program at the Australian Bureau of Statistics [ABS]. Within that program we are responsible for collating deaths for Australia and indeed coding cause of death information for Australia that creates the national mortality database. That is actually James' role. He leads the team that does that, so I will let James talk a little bit about that work. The other matter I thought I would mention that is within our submission also is that we have had some work in the past where we have been responsible for some mental health data collation. Back in 2007 and also in 1997 we ran a national survey of mental health and wellbeing. The target age range for that survey was actually 16 to 85 years, but I could tell you, if you like, some information from that survey itself around mental health at some point today.

The other thing that the ABS is involved in is the longitudinal study of Australia's children. The conduct of that particular survey is a tripartite arrangement. The ABS has a role conducting the survey, providing interviewers, et cetera, whereas the Australian Institute of Family Studies actually collates and reports that information, and it is supported by the Department of Social Services. Since we made our submission I think we have released some detailed information about mental health and wellbeing amongst 14- and 15-year-olds, which I would be happy to refer you to. It actually was released by the Australian Institute of Family Studies. It included information on self-harm behaviour and suicidal ideation for that particular cohort, the 14- and 15-year-olds, in that survey. I will let Mr Eynstone-Hinkins give you some detail about our cause of death data work.

Mr EYNSTONE-HINKINS: We look after the compilation of the national mortality data—that is, all deaths that occur in Australia regardless of whether they are certified by a doctor or referred to a coroner. We compile the data based on the International Classification of Diseases [ICD], which is a World Health Organization governed classification and allows international comparability of all mortality statistics. The work that we do is any deaths that occur from intentional self-harm or suicide are coded from information on the National Coronial Information System. Obviously we were talking about the NCIS just before. We have quite a unique system in Australia in the sense that the National Coronial Information System is a very rich repository

of information on deaths referred to a coroner. It contains information from police reports, autopsy reports, toxicology reports and findings from a coroner, whereas in most countries cause of death statistics are mostly compiled from death certificates only and they only get very small amounts of information from the coronial system. We are quite lucky in that sense.

The move to using a national coronial database perhaps had its teething problems back in the early 2000s and there have been studies since that showed some under counts of suicide deaths back in the early 2000s. It was a lot to do with the timeliness of report attachment on to the NCIS as the basis for being able to code causes of death. In response to that the ABS implemented a revisions process around 2006. Since then there has been strengthening both of the connectedness of the NCIS with the coronial system and also process improvements and timeliness improvements that mean that we are currently able to get very close to a final number within the first year after a reference period. We are now able to publish data nine months after the end of a particular year, which is probably again pretty much leading timeliness around the world, but we still go ahead and revise data over a three-year period so we can capture as much information as possible that comes through that coronial system. If there are other deaths to be identified we will capture them through that.

In terms of dissemination, the ABS publishes suicide data. We also have consultancy services if people are looking for customised tables. We also pass data back through the Registry of Births, Deaths and Marriages, which allows unit record data to be made available for legitimate research purposes. One last thing is that we work pretty closely with the stakeholders around suicide both in the non-government area and government area. We have been involved in work where people are looking to extend the foundation of information available for suicide prevention. One thing that we are trialling this year is, with the information on the coronial database around psychosocial factors associated with suicide deaths, we are trying to code those alongside the causes of death. It is not a traditional ICD role but it is something that we are trialling and we hope to be able to try to embed that. We are working with the World Health Organization to embed that in the next iteration of the classification. We are also looking ahead to see if there is a sustainable way to be able to continue to do that. It is quite a large task but one that could be very worthwhile.

The Hon. PAUL GREEN: Do you have some comments on cyberbullying and what you are seeing there? What are the statistics there? Is there an increase or is it a perceived public increase because the media is across it?

Mr EYNSTONE-HINKINS: This is exactly the sort of thing that we are looking to try to capture through this process. Things like mentions of bullying or mentions of domestic violence, mentions of having been in the prison system or something like that, it is a question of being able to find a way to capture that information. Again, just coming back to what I was hearing before, it does not always tell you whether or not that had a direct link to the person's death. But if there is a mention there and we can find a way to put a code alongside then it creates a better resource for people to say that this might be something worth further investigation. I do not have any evidence at this stage as whether or not that is increasing or decreasing.

The Hon. PAUL GREEN: On the last page of your submission you say:

> For example, results from the 2007 survey reported that of young people with a mental disorder, 8% had suicidal thoughts, plans or attempts in the year prior to being interviewed. The rate was almost three times higher for young people with Affective disorders, with almost a quarter having suicidal thoughts, plans or attempts in the previous year (23%).

I guess that relies on the fact that they want to declare that information. My question is: How many people are not declaring that they have had those thoughts, ideations or attempts?

Ms BOLAND: That data that you are referring to comes from the National Survey of Mental Health and Wellbeing. The way that is conducted is we have personal interviewers who will interview the people. That particular survey used an international instrument to firstly determine whether the person had a mental health disorder. The data that you are quoting there about affective disorders, it first would have been determined through the use of this instrument to identify this person had an affective disorder. Then, of course, as you acknowledge, the questionnaire would have asked people about suicidal thoughts and those sorts of behaviours in there. Of course, you are right, it is dependent on the respondents acknowledging that. I think we just try to design these surveys and create the appropriate environment to get the best information that we can.

The ACTING CHAIR: You rely on information which is provided to you by the national coronial body. Often that information can be two years old by the time it gets to you, so it is up to date only insofar as the underlying bodies are dealing with matters expeditiously. Do you have any comment about how they might more quickly provide information or reach determinations?

Mr EYNSTONE-HINKINS: There is a very long, evolving story when it comes to the NCIS and it is connectedness across the jurisdictional coronial system. We are very heavily reliant in the first place on police reports. Obviously, the speed with which police reports can make their way through the coronial system and into

the database critically changes how long it takes us to be able to identify whether a suicide death has occurred. The complexity of a system that relies on all of these different reports coming from different sources and finding their way onto a national database means that there are often discrepancies between how much information is available for each death. If something takes two or three years, if we have got one piece of evidence to work with that is usually very useful.

There is a coronial court coding system for an indicator of self-harm and in the absence of something else that is really important. But once we have the full set of information we can be a lot more confident as to the fact that this is a suicide death. To give some idea of numbers, in 2007 when the revisions process was first implemented I think the revisions process over a three-year period identified around 300 additional suicide deaths. But in recent years it is down to around 40 or 50 additional suicide deaths over the period. Things have improved remarkably and perhaps in the last four or five years especially. It does not mean it cannot get better. It certainly can and still be more timely and more complete.

The ACTING CHAIR: Would the ABS have eyes on how many young people took their own life by suicide in the 2017 year?

Mr EYNSTONE-HINKINS: We are in the process of coding all of those deaths now. We literally start around about now, about a month ago, and we pay very close attention to anything that appears like it could be a self-harm death. We go through all the reports that are on the coronial system and we will make a preliminary code available soon.

The ACTING CHAIR: The information you rely on is the material that is just on the coronial system, which is coded into that system. The determination may not have been made but it has been coded into the system as being a self-harm event.

Ms BOLAND: It will contain the police report, for example, so James's team will review any information that is placed in the system. Generally the police report is the first thing in there. So they will review that report and make a determination around the cause of death based on that information.

The ACTING CHAIR: In terms of developing programs, we have got the event of potential self-harm as the cause of death. How do we develop programs for identifying other factors such as identifying mental illness factors or whatever it may be? What is the process for garnering that information for self-harm, for example?

Mr EYNSTONE-HINKINS: This is the classification that we use for coding all deaths. It allows you to code an underlying cause. So the underlying cause of death in this case would be intentional self-harm. It also allows us to code additional information that could be relevant to the chain of events leading to death. Effectively that is where signs of mental disorder and that kind of thing can be coded. We are just expanding that out—this is what I was talking about earlier—to also find a way to capture information about other relevant factors. It is not traditionally part of cause of death coding but something that we thought could be very useful.

The ACTING CHAIR: I am interested in the whole scope of the additional factors you are looking for at the moment. Mr Green, for example, identified cyber bullying as something that you might be looking for. What else are you looking for?

Ms BOLAND: The staff on James's team will read the police reports in full and then, ultimately, once the coroner's report is added to the National Coronial Information System [NCIS] data, they will read that in full. So if there is information in there, for example, about cyber bulling, that may be something that we start coding over time. We are just starting to pilot this now to gather this extra information on psychosocial factors associated with the death that was recorded. It is all dependent on what was actually written into that police report and, ultimately, the Coroner's report at the end. If it is not in there we will not know about it.

Mr EYNSTONE-HINKINS: The range of factors that we are looking at initially are things like domestic violence. I know that bullying will be one of them; I am not sure that cyber bullying is necessarily separately identified.

Ms BOLAND: We are quite beholden to the classification system underpinning this. So, if there is a classification for bullying but there is not yet a sub-classification for cyber bullying, we just classify to the higher level.

Mr EYNSTONE-HINKINS: That is where we are effectively looking to influence in the next iteration of the classification. It should be released quite soon, although adoption of it will take some time. We have a much better range of available factors or codes for factors that can be included. We have been able to be quite influential there and a gentleman named Professor James Harrison, who works for the Australian Institute of Health and Welfare at Flinders University, has been assisting with that development work.

Ms JODIE HARRISON: Your coding for the underlying issues such as bullying comes from police reports and coroner's reports?

Mr EYNSTONE-HINKINS: Yes.

Ms JODIE HARRISON: The previous witness said that there were 700 suicides in any one year and only a portion of them go to an inquest. Does your data only take from coronial inquests or does it take from the overall coronial findings?

Mr EYNSTONE-HINKINS: In New South Wales it is taken probably in the main from the police, the autopsy and the toxicology reports, and between those sources of information you have a very rich picture of what actually happened. The coroner's findings are generally quite limited unless a death goes to inquest. We will work with whatever we have. The police reports can be very detailed as to what happened in a particular death and often we are looking to confirm that through what the pathologist has to tell us. In the case of drug-related self-harm deaths in particular, we look at the toxicology to understand what happened there in more detail.

Mr MICHAEL JOHNSEN: Is the information you have to date qualified enough to be able to identify trends?

Ms BOLAND: Causal trends?

Mr MICHAEL JOHNSEN: Causal, geographic, anything you like.

Mr EYNSTONE-HINKINS: The basic information we have about capturing in the first place the number of suicide deaths and the suicide rate I think is very complete. We capture very detailed geographic codes. In fact, we capture down to something called Mesh Blocks, which is only a handful of houses in a geographic location, and obviously we have all the key demographics of the person. All of those things give us a very strong indicator of trends over time. I think moving into things like psychosocial factors—at the moment that work is effectively experimental. We will work with people who have more experience in that, to look at how well we are able to capture that information through the process we are using and how best that information could be used. It would then be a couple of years before we could determine how well it can measure trends over time, in terms of changes and factors. But the reality is, at the moment people are very much reliant on individual studies maybe looking at only one factor at a time. If we are already working with this information, and we can find a way to capture it as we go through the process of looking just at what the self-harm is there, then I think this could become a very useful resource.

Mr MICHAEL JOHNSEN: Do any government or non-government organisations access this information to try to identify any sort of trends?

Mr EYNSTONE-HINKINS: All government can apply for access to the National Coronial Information System research to do individual studies. I am quite certain that there are many studies going on. It obviously requires ethics approval and other things. Like I say, those things will be focused on one factor at a time perhaps or whatever the particular area of research might be. If we can help people to identify what sort of things would be better to look at through the process that we are trialling, that might create a better foundation for people who can move further with the work they are doing and perhaps get closer to identifying what the key factors are that need to be addressed in prevention.

The ACTING CHAIR: Would you have the information if I said to you, "I would like to know how many young people self-harmed in circumstances where there was an absent father"?

Mr EYNSTONE-HINKINS: No, that is something that we would not have.

The ACTING CHAIR: If that was something that was interesting to the community at large, would you have the capacity to be able to drill down to that material?

Mr EYNSTONE-HINKINS: Theoretically, if we knew that people were looking for that particular thing and if that information was captured on the Coroner's database it could be captured alongside the data.

The ACTING CHAIR: Or from some other site?

Mr EYNSTONE-HINKINS: Yes.

Ms BOLAND: We have done some work in the past where we have linked all of our mortality data to the census that is undertaken. You have to remember that the Australian Bureau of Statistics legislation is such that we cannot release any data in a manner likely to identify. So we have linked deaths data to the census and then made that available through secure research facilities to genuine researchers. So they could look at some of the demographic patterns associated through someone's census form with some deaths for the particular years

that we have linked. Those sorts of studies could be possible as well. On a household form in the census, for example, where you might report the family grouping sort of dynamics, you could look at suicide deaths and then their associated census forms.

The Hon. GREG DONNELLY: I go to your submission, specifically the third paragraph on page 3. Please elucidate and give us findings or research done on the matter of young people attempting to harm themselves but not to the point of suicide. Because they are young they, perhaps do not fully comprehend the consequences of such an act. I am no specialist in the area, but anecdotally we hear stories about young people self-harming in an attempt to draw attention to themselves because of what is happening in their lives that is causing great anxiety or concern.

It is unusual for young people to kill themselves, to put it bluntly. Understanding the consequences of such an act tends to come with the brain maturing, and we understand that brains do not fully mature until a person is in their mid-twenties. How do we understand the suicide of a young person? Do young people set out with the intention to kill themselves, or are there instances of young people trying to attract attention or call out for assistance by self-harming? That is a general question, but I am trying to discern whether such acts are intended or unintended.

Mr EYNSTONE-HINKINS: These are the challenges, especially for the coroners. I cannot answer the question about people's intentions, but our system is based on using the international classification of diseases and the definition that we are using is intentional self-harm leading to death, although in some ways there may be some difficulties within the coronial system in saying whether someone intended to die by suicide or not. If a coroner makes an open finding in terms of intent then we can still identify that death as an intentional self-harm death within the national suicide data, because the person died from an act of intentional self-harm. If the Coroner says that this was an accident then we will say that this was an accident. We will follow the Coroner's finding, unless they leave the intent open. But it does ensure that we are able to capture a fairly accurate picture of the number of deaths that occur from a self-harm event—of course, whether or not somebody intended to go through with something that was just a cry for help, or something like that, we do not know that.

The Hon. GREG DONNELLY: Picking up on your point in that paragraph, you say that in the case of younger people it is possible that a coroner will determine the child could not have foreseen or comprehended the likely outcome of an act of self-harm. Are you saying that in such cases there is an open finding?

Mr EYNSTONE-HINKINS: It is possible that a coroner may leave that as an open finding in terms of intent.

The Hon. GREG DONNELLY: You said that notwithstanding the determination of an open finding, you still may categorise it as a suicide. Is that the case? What criteria are used by the Australian Bureau of Statistics [ABS] to make that determination?

Ms BOLAND: We need to code to the underlying cause of death. If the underlying cause of death, the thing that caused this person to die, was the result of a self-harm that is what we would code.

The Hon. PAUL GREEN: How do you do that if, for instance, a 17-year-old male drives his car into a tree?

Mr EYNSTONE-HINKINS: Those are the really difficult grey areas for every country in the world. Anyone who is working in this area understands that there are deaths where there is no note, where an accident has happened and it could have been somebody who fell asleep at the wheel and drove off the road, but it may not have been. The only person that knows is the person who was driving the car. Those sorts of events will likely end up being coded as accidents, unless the Coroner can find evidence to say that something was happening there. My point is that we will follow the Coroner's finding around intent, unless they leave that open. It would be a very rare circumstance where that might happen, but if it is a clear act of self-harm that has led to death and yes, there are some other circumstances where we cannot say it is an accident unless someone tells us it is an accident. We are really only coding the information that is available to us, but it can be complex because there are grey areas, and the coroners can tell you the many different circumstances they have to decide on.

The Hon. GREG DONNELLY: A drug overdose would be another problematic area, would it not?

Mr EYNSTONE-HINKINS: Yes, it would be. One of the advantages of having toxicology reports would be if somebody has taken a few too many drugs of minor amounts, versus somebody who has taken a clearly very large overdose or something. Those would be telling factors that would appear in the reports.

Ms BOLAND: Where there may be an open finding, we may have to make a judgement, in our coding, as to whether or not the death was intended or not. It might be that we are just guided by, for example, the police report mentioning a suicide note. That might guide us.

Ms JODIE HARRISON: I would like clarification on the drug overdose statement. Generally, if it is a large amount of drugs, would you classify that as death by intentional self-harm?

Mr EYNSTONE-HINKINS: It is very complicated. Because of the information that we have available, often you will see that someone has left a note and described what has happened. The drugs are then the mechanism of death; somebody has clearly left a note that they intended to die. But there are any number of circumstances, and those things are all documented in long written reports on the Coroner's database and the coders go through and read the reports to understand the circumstances.

Ms BOLAND: As an example, there may be an open finding and there might be quite a lengthy history of drug abuse. In those cases, we might decide that, because there was no reported suicide note and there has been an open finding, we will then also assume it is an accidental overdose.

Mr EYNSTONE-HINKINS: The truth is that we are not deciding on the cause of death in the sense that that is the job of the coroners and those investigating the death. We are assigning a code, but these examples are all ones showing that it can be complex—and it can be complex. Many countries are reliant on a single tick box on a medical certificate of cause of death and in one line that a person died by the mechanism of hanging, or something like that, whereas we have all of the investigative information that is available. That is fantastic in the sense that we are far more able to identify potential suicide deaths, but obviously it also makes it far more complex in that you have all of the detail around that and not all cases are cut and dried when it comes to how the person has died.

The Hon. GREG DONNELLY: I do not have a morbid curiosity, but in the next paragraph you make reference to a particular "game" which sometimes has the tragic consequence of leading to death, which is perhaps not intended. In terms of establishing what might be, dare I say, a sort of a trend or almost a sort of fashionable game that comes into vogue for a time and then disappears and comes back and then something else replaces it, how do you find out about those things? To be perfectly honest, I had never heard of that until I read it in your submission. I do not wish to be morbid, but presumably there are times when particular actions appear to be operating in society and that might wane and something else emerges. How does the Australian Bureau of Statistics, as a body, develop an understanding of those things?

Mr EYNSTONE-HINKINS: I think probably in this case we are talking about the coroners as the ones who will identify that sort of thing.

The Hon. GREG DONNELLY: So that will be in the coroner's report?

Mr EYNSTONE-HINKINS: I believe the New South Wales Coroner actually flagged this as a public health issue and obviously a very dangerous thing for children to engage with. It is probably in this submission more as an example, again, of a really complex area for identifying how that person has died.

The Hon. GREG DONNELLY: But the ABS is obviously focusing on the material before it that presents or is available?

Mr EYNSTONE-HINKINS: That is right, and we will see mentions of something like that in the reports.

Mr MICHAEL JOHNSEN: Going back to the data that you have and the potential for looking for trends and things like that, is this inquiry able to access data that may help inform us?

Mr EYNSTONE-HINKINS: Yes.

Ms BOLAND: Yes. You could put requests to us. We are bound by confidentiality rules, so we can never identify individuals or put them at risk of that, but we could tabulate information as you request.

The ACTING CHAIR: If I asked you a question like, "How many deaths of young people last year occurred by motor vehicle accident which were unexplained in cause?" you would be able to give us that information?

Ms BOLAND: Yes, providing that number is not lower than a certain threshold, because of our confidentiality rules.

Mr EYNSTONE-HINKINS: I think the question there though, the circumstance around a death—

The ACTING CHAIR: That is my next question.

Mr EYNSTONE-HINKINS: —at this stage we cannot answer the question beyond that there were this many intentional self-harm deaths that occurred with a motor vehicle as the mode of death, and there were this many accidents.

The ACTING CHAIR: Or unexplained?

Mr EYNSTONE-HINKINS: Yes, "unexplained" is likely to end up in an accident unless it is proven to be something else. So they cannot really be separated out from other motor vehicle deaths. This is where we are hoping to add a layer of richness to the data set; but that will be moving forward and it is not what we have now.

The ACTING CHAIR: If I asked you how many young people have committed acts of self-harm in circumstances where they have had an argument with mum that morning—

Mr EYNSTONE-HINKINS: That is not available at this stage. I believe that would be, again, one of the additional codes that we are trialling as we code this year's data—so looking ahead. An example of a family argument or something like that is something that we could put into that additional data. We think that is the sort of thing that people will want to know about, and if we can find a systematic way to do that that is useful for people.

The ACTING CHAIR: Is that something that a police report would have picked up?

Mr EYNSTONE-HINKINS: Yes, the circumstances around a death, what happened before and after, that is the sort of thing that would be in it.

The ACTING CHAIR: Do you ever make recommendations to the police about additional material that might be helpful if they collected that as well?

Mr EYNSTONE-HINKINS: Probably not us. I know that the National Coronial Information System people have worked with the jurisdictional police forces to try and standardise police forms because there would be some value in having a more defined set of questions that basically enhance the range of information available.

The ACTING CHAIR: There is a document that is a pro forma-type police—

Mr EYNSTONE-HINKINS: There is a different one for each State and Territory. I believe it was the Form 1s, but it escapes me which jurisdiction has what might be considered the best of those. But from an ABS perspective again, if there was more consistency across those sorts of forms and the questions asked were structured in a certain way, that could be—

The ACTING CHAIR: Have you seen one of those documents?

Mr EYNSTONE-HINKINS: I have, yes. We have to access all of the police forms on the Coroner's database as we do the job.

The ACTING CHAIR: We might want to look at one of those documents to see the sorts of things that the police are looking for when they are carrying out an investigation for the purpose of preparing a report. Thank you very much for appearing before us today, it has been very helpful. It is a very interesting area of work. If we have any further questions—I think I made this clear to you before—and we want to put them in writing, you would have no problem with answering those questions?

Ms BOLAND: Not a problem.

Mr EYNSTONE-HINKINS: Not a problem at all. That would be fine.

(The witnesses withdrew)

(Short adjournment)

PHILIP HAZELL, Independent Member, Child Death Review Team, NSW Ombudsman, sworn and examined

MICHAEL BARNES, NSW Ombudsman, and Convenor, Child Death Review Team, affirmed and examined

The ACTING CHAIR: I reconvene the Committee hearing for the inquiry into the prevention of youth suicide. We now have with us Mr Michael Barnes, the NSW Ombudsman and convener of the Child Death Review Team, and Professor Philip Hazell from the Child Death Review Team. I welcome you as members of the Child Death Review Team. Clearly, the material that you have to tell us about is very relevant to the inquiry that we are conducting and we are very grateful for you being here today. You have probably received the information pack that we sent.

Mr BARNES: Yes, we have, thank you.

The ACTING CHAIR: And you are aware of the standing orders relating to the giving of evidence?

Mr BARNES: Yes.

The ACTING CHAIR: It is our practice to invite witnesses to make an opening statement in respect of the issues which they propose to cover. Do you wish to make an opening statement?

Mr BARNES: I do. That would be of benefit to me. I should acknowledge at the outset that I will talk mainly about process and systems. The real content expert, of course, is Professor Hazell. I anticipate that he will be able to provide you with valuable information about the serious issues we are discussing today. I want to touch very briefly on a number of issues: the role of the committee and the Ombudsman's office generally in reviewing child deaths; the scope of the problem; the data challenges associated with it; the benefits of a suicide register, as we see it; the complexity of the causes of child suicide; and the need for an integrated system. I know that sounds like a lot but I assure you it will only take me six or seven minutes to briefly touch on those things.

First, the aim of the committee. The aim of the Child Death Review Team is to help reduce the likelihood of deaths of children and young people aged from birth to 17 years. We report directly to Parliament via a biennial report of child deaths, and research reports that focus on issues relating to the prevention or reduction of child deaths. As NSW Ombudsman I have a separate and additional responsibility for reviewing what are referred to in the Act as "reviewable" deaths of children. A suicide death is reviewable if the child was in out-of-home care at the time he or she died. Our role includes maintaining a register of all child deaths in New South Wales. We seek to identify trends and patterns in child deaths, and make recommendations to help government, services and the community to prevent those deaths. Data from the register about suicide is presented in the appendix to our written submission to this committee, and I now have data for 2017 to which I will refer in a moment.

That data shows that the suicide mortality rate is higher in older age groups of children. Sadly, it is consistently the leading cause of premature death in the 15- to 24-year age group in both New South Wales and nationally. In the 10 years 2008 to 2017, suicide accounted for more than one-third of external cause deaths in the 10-17 age group. For the older cohort, the 15- to 17-year age group, it is higher. Suicide accounts for nearly half of all external cause deaths. I said I would come back to the 2017 statistics. While our submission notes that there has been no statistically significant change in the suicide mortality rate of children and young people over the previous 20 years, in 2017, both the number and the rate of suicide deaths in New South Wales is the highest in 20 years. Last year 29 young people took their own lives. What makes this particularly significant is that there has been a continual decline in the rate of child deaths over that same period. Suicide is one of the few causes of death—and the only external cause—that has not reduced.

I note that data collection is an issue referred to in the committee's terms of reference. With respect, that is appropriate. Accurate, reliable and standardised data in relation to suicide and suicide attempts is necessary for a number of reasons, including: to understand the extent and cost of suicide and self-harm; to target research effectively; and to develop appropriately targeted intervention and postvention strategies. It has been recognised for decades that our suicide data almost certainly underestimates the scope of the problem. It is uncertain because—unlike most other deaths—in these cases the manner of death cannot be conclusively ascertained by autopsy or scene investigation. It requires assessment of the dead person's understanding and intention. It is particularly relevant to children who die as a result of their own act: Did they really understand the effect of what they were doing and the likely outcomes, and did they intend that outcome?

In 2010 a Senate standing committee reported on what it called the "hidden toll" of suicide in Australia and among numerous recommendations they made seven designed to improve the accuracy of suicide data. For over a decade I have been a member of a national committee to whom some of those recommendations were

aimed but I regret to say that progress has been slow. Similarly, the recommendations of the Senate standing committee directed to the Standing Committee of Attorneys-General [SCAG]—as it was then called—also seem to have stalled. This committee might consider revisiting those recommendations.

I would like to raise for this committee's consideration the benefits of a suicide register. The NSW Child Death Register captures data relating to a wide range of information about suicide of children. However, the role of the team and the register are limited to children under the age of 18 years. The concept of a suicide register for all intentionally self-inflicted deaths should, in my respectful submission, be closely considered. Such a register exists in Queensland and Victoria. Those registered provide information necessary to get a deeper understanding of the causes of, and thus the remedies for, suicide in young people not captured on our child death register because of its age limitation, and indeed the population generally. I would be happy to discuss that further if the committee is interested.

The connections between demographic and social variables and the deaths of children generally are complex, and this is particularly the case with suicide. I will make a few points to illustrate this complexity. This inquiry's hearing in the Hunter in 2017 focused on suicide among Aboriginal and Torres Strait Islander young people. Our data indicates that the suicide mortality rate for Indigenous children aged 10 to 17 is around four times that of the non-Indigenous cohort. We have also identified that the suicide rate for young people with a child protection history is about four times higher than for those who have not had contact with the child protection system. However, in 2014 the Australian Institute of Health and Welfare analysed our data for links between mortality rates and child protection history.

The institute found that among the deaths of all children with a child protection history—and after controlling for age, gender, remoteness and area socio-economic status—Indigenous status was not at all relevant or significant. In relation to suicide deaths the institute also identified a complex relationship between the socio-economic status of the area in which young people lived, child protection history and suicide. In that study the highest proportion of young people without a child protection history who died by suicide were from the most socio-economically advantaged areas. This illustrates well why a comprehensive register of information about suicide and attempted suicide across all age groups is important. It would be the best way to monitor what is happening and to analyse the range of risks and variables that may contribute to suicide.

The final issue I would like to touch upon is the need for an integrated system of prevention and intervention strategies to reduce youth suicide. Every year our reviews identify suicide deaths from across a spectrum of risk. Some young people who died were known to be at high risk. Others had identified risk factors such as depression and self-harming behaviour. But in some cases no prior risk factors could be identified, even retrospectively. We know that there are many thousands of children whose lives exhibit characteristics associated with a higher risk of suicide and who, as a result, might be seen to be at an elevated risk of suicide—a chronic risk, if you like. However, it is often very hard to identify those who might actually take their own lives soon, such as would justify an intrusive intervention—those who are at acute risk.

Because of that the best approach must be to move as many as possible from the chronic risk cohort to a healthier place. We need to ensure those young people who display suicidality or who are at high risk receive competent and sustained clinical care. We need to provide accessible intensive case management and consistent therapeutic care. However, we also need early intervention and universal strategies—such as those delivered through schools—to build resilience and improve mental health at a population level to reduce the number of children who may become at risk of intentional self-destruction. Thank you for your attention. Professor Hazell will now address the Committee.

Professor HAZELL: I would like to amplify a few points Mr Barnes made. The first is the observation from the Child Death Review Team [CDRT] data that four out of five young people who die from suicide are already known to services. Their health or their difficulties were already identified and in some cases, but not all of them, and their risk of committing suicide had been identified. We in New South Wales are very good at identifying risk. That is one of the strengths of this State. We have some very good training programs run by agencies such as EveryMind and HETI, which train people to identify risk and to escalate it.

Our weakness is in risk containment and risk management. I would like to propose that there be some shifting of training resources to considering building workforce capacity to manage and to contain risk. We need a number of individuals in our services who are effectively black belts at managing people who are at heightened risk of suicide and who can guide the management of treatment of these people.

The second point I want to amplify relates to the two vulnerable and overlapping groups who appear in the CDRT data; that is, children with a child protection history, particularly those who have been in out-of-home care, and Aboriginal and Torres Strait Islanders. These data stand out like a beacon compared with the rest of the data. I make the point that this is old news. We have been aware of the fact that these groups of young

people are at risk of a range of poor health outcomes. The challenge, or the problem, for us is that other issues sometimes grab people's attention through promotion by lobby groups or the media, but they are not the main game or the most important issues facing our community. An example of that is cyberbullying. It is important and we know that it is a factor in increasing the risk of self-harm, but its direct points with suicide are yet unproven. However, at the moment one would think that that was the key cause of suicide now in our community.

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

The fourth point is that youth suicide prevention strategies in New South Wales should not be standalone. One of the other witnesses—Ms Jaelea Skehan—made the point that youth are not the most suicide-prone group within our community; it is an older age group. There is nothing specific about being a youth that puts someone at risk of suicide. That is not to say that we do not wish to reduce the number of deaths from suicide as best we can. However, youth suicide prevention strategies are better placed within a whole-of-lifespan approach. Clearly there will be some issues that are specific to youth within that lifespan approach. However, most of the strategies that have been identified to potentially reduce suicide generalise across the age span.

I have a final point to make. It may sound pedantic or semantic, but suicide prevention is a process and our goal is reducing deaths attributable to suicide. I know it sounds as though they are the same thing. However, reducing deaths from suicide is measurable. We can measure suicide prevention activities, but we do not know how many suicides we have prevented. We can measure death rates.

The ACTING CHAIR: That was very informative.

Mr MICHAEL JOHNSEN: Thank you for appearing at today's hearing. Professor Hazell, you mentioned organisations working in this sphere and you said that New South Wales is doing well in identifying risk factors, people at risk and so on. There have been significant increases in resources allocated to this area, yet we see increasing rates of suicide. How do we reconcile significant increases in resources and organisations dealing with and identifying the risk factors with increased rates of suicide?

Professor HAZELL: First, the suicide rate has not increased. There have been variable suicide deaths in the under-18 group across the period that the CDRT has been monitoring deaths. We have seen an upswing in the past three consecutive years. However, there has been variability in the data throughout the monitoring period. The important point is that suicide deaths have remained constant while deaths from other causes have decreased. There is something we are not achieving in suicide deaths that we are achieving in other spheres of health.

In terms of the question about increased resources being translated to outcome, the resources are being directed to training, to early intervention, to school-based programs and so forth. With some of these activities we would not expect the benefits to be immediate. If there are going to be benefits, they will be longer-term benefits. We must invest and see what happens. In terms of workforce training, I think it has been very successful. There has been an extensive and comprehensive rollout of training across the State. However, as I said in my opening remarks, what we are missing is training in risk containment and management. We now have many people who are good at identifying risk, but relatively few people who are good at managing it.

Mr MICHAEL JOHNSEN: That leads to my second question, perhaps to both Mr Barnes and Professor Hazell. Your submission refers to data collection and reporting of suicide. Can you expand on what you mean by "reporting of suicide"?

Mr BARNES: You know that the data we generally rely on comes from the Australian Bureau of Statistics, and it gets its raw data from the National Coronial Information System, which gets its information from coroners around the country. All unnatural deaths are reported to coroners, who should make a finding on the manner of death, whether it was accidental, intentionally caused by another person, or caused by the deceased person. That is then included in our statistics. That is the reporting. However, the classification must be undertaken by coroners or someone in the National Coronial Information System.

Mr MICHAEL JOHNSEN: So you are not talking about reporting in as much as providing information. Your submission refers to public information or publicly available information. You are not necessarily talking about public reporting, as such, of incidents, trends and so on. Is that correct?

Mr BARNES: You are right that that was a sensitive issue. The media was accused of contributing to the problem in the way it was reporting. I think that has been addressed. It is rare to see accounts of a suicide that glamorise it or refer to methods. That sort of reporting has been remediated.

Mr MICHAEL JOHNSEN: I have one further question. It is directed to either of you. In the context of opening up community discussion on issues of domestic violence, which I believe is the best way to get to the root of the problem, do you think that this reporting in any capacity has value in opening up the discussion?

Mr BARNES: Professor Hazell is probably better placed, but can I make an observation that there is a growing concern among people in the sector that we are drawing so much attention to it that young people who might not previously have considered suicide are now considering it an option. Phone apps they download that talk about suicide is not something that happened a decade ago.

Professor HAZELL: I believe that we do need to have public discourse about this problem, but the public discourse does need to be carefully managed and specifically we need to be cautious about the way death and suicide is portrayed both in terms of method but also motivation. We need to be sure that in that public discourse we do not make some people worse.

Mr MICHAEL JOHNSEN: It is complex.

The Hon. PAUL GREEN: Professor, you mentioned earlier when breaking down cyberbullying that it is more to do with self-harming. On page 7 of the report you talk about "our reviews identify that close to half of all people who die by suicide had engaged in self-harming". Would you not say it is linked? The media is talking about cyberbullying and the Dolly case in the Northern Territory. Would you not say that if half of those are related it is a significant statistic?

Professor HAZELL: You have touched on a challenging issue. That is, the relationship between self-harming behaviour and death from suicide. Self-harming behaviour is very prevalent in our community. Around 10 per cent of young women in the age group we are focusing on in this hearing and about 5 per cent of young men engage in self-harm every year. Some of those young people will engage in self-harm multiple times. If you look at the rates of self-harm versus the rates of suicide the proportion is about tenfold difference, even a hundredfold difference. Most young people who engage in self-harm are not suicidal and they are not in immediate danger of suicide. Even people who have got very close to suicide or eventually die from suicide report self-harm that was not suicidal in intent. Paradoxically, some people will self-harm to stop the suicidal thoughts. It is a complex relationship. On top of that mostly when we look at the effectiveness of measures to reduce suicide we have to use proxy outcomes. One of the proxy outcomes that is used is self-harm. I have already illustrated the problem; a lot of self-harm is not related to suicide death. It poses a considerable challenge.

The Hon. PAUL GREEN: Mr Barnes, you spoke about 2017 in a particular age group. Overall we have seen an incline of suicide.

Mr BARNES: As Professor Hazell said, there was a slight kick-up over the last three years.

The Hon. PAUL GREEN: There is a film called *Thirteen Reasons* about exposing and having the conversation. Do you think that would have had an impact on making kids aware of such a topic and considering such thoughts?

Mr BARNES: There is no evidence that would demonstrate that, but I know a lot of people in the sector were particularly concerned about that movie and wanted to explore whether it had any impact. That is not something that would be easy to do. Glorifying or suggesting to an audience that suicide is an appropriate response to personal difficulty is not going to be helpful, to demonstrate a direct correlation between things like that and suicide would be difficult or impossible. Professor Hazell properly pointed out there is no proven correlation between self-harming and suicide, I think we all agree it is an unhealthy manifestation of behaviour that the community would benefit from if we could reduce.

The Hon. PAUL GREEN: It is a bit of a perfect storm for such a sad thing. You have movie makers making movies that are exposing young people to considering it. You have apps for mobile phones where they can see what to do, or an indication in the cyberworld how to implement such things. Then they have their own world to deal with of cyberbullying or self-harming. It is the perfect storm for kids to push them over the edge.

Mr BARNES: There are lots of unhealthy attributes of our society, yes.

Ms JODIE HARRISON: Thank you for your written and verbal submissions. I have a question regarding people who are at increased risk because they are children who have been reported to Family and Community Services [FACS]. I note in your submission you have made recommendations to FACS about changes that should be made. I am wondering what those recommendations were that the Ombudsman made to FACS and what the response has been?

Mr BARNES: I do not have it at my fingertips but I am happy to take it on notice if it will be of assistance.

Ms JODIE HARRISON: I have a question about the Aboriginal and Torres Strait Islander suicide crude mortality rate. It has increased sixfold over the last 15 years as a proportion of overall deaths. What are your views on the cause of that increase?

Mr BARNES: I think other things have got better. If you look at the main other external causes there has been a reduction in the rate of children dying in motor vehicle accidents, the rate of children drowning has decreased, although you would not think it from the media. Swimming pool safety has been getting greater focus. The proportion of children dying from suicide has increased because the other rates have reduced. Professor Hazell said the rate has remained fairly constant although it has kicked up over the last three years, the rate per 100,000. We are still talking about 1.6 per 100,000 compared to 12 per 100,000 in the general population.

The ACTING CHAIR: It is not the number; it is the proportion?

Mr BARNES: Yes.

Professor HAZELL: We do not know, but it appears Aboriginal children manifest with the highest level of multiple risks. It is multiple risks to health, mental health, education and their capacity to live with their families. That places them at a high risk of a number of serious outcomes including suicide. There is another possibility but it is pure conjecture, that is that we have a slow burning cluster occurring. Clusters are usually considered in terms of relatively short aggregations of suicide in time and place, sometimes method, sometimes the characteristic of the people involved. We sometimes see these other kinds of clusters that are much slower, but they keep recruiting people with similar characteristics into the cluster.

The Hon. PAUL GREEN: You say it is four times more prevalent in Aborigines and then four times more prevalent in child protection cases. Are those statistics because there is a high removal of Aboriginal children out of the community and into out-of-home care? The FACS inquiry shows that is growing again. Have you strained out those child protection cases for Aboriginal children in that statistic?

Mr BARNES: I am not aware.

Professor HAZELL: The analysis of these data demonstrated that once you took all other factors into account Indigenous status was no longer a risk factor for suicide. It was all the other multiple factors that led to a young person being in out-of-home care. The problem is that Aboriginal children are far more likely to end up in out-of-home care.

The Hon. PAUL GREEN: That is what I am saying.

Professor HAZELL: Yes.

The Hon. PAUL GREEN: Does that affect that statistic of four times?

Professor HAZELL: Yes.

The Hon. GREG DONNELLY: I will go to the second last page of your submission and then the last page. The second last page has the number 18 on the bottom. The graph reflects the data in the table below. Looking at that, could one or both of you give us some insights into what that is telling us. We can see movements up and down—looking at it from left to right. What can we say about that? Is there anything we can say, with any degree of certainty, about what we are looking at there or are we looking at a graph that is going up and down and moving across? I want to look into that in a bit more detail. What is your interpretation of what we are looking at there?

Professor HAZELL: The variability in the data. If you look at anything, and measure it over time, it will fluctuate. It is difficult to draw any conclusions about why there were years when it spiked and years when it dipped, but the trend line is more or less consistent. The data show that there was a convergence through 2016 of the death rate between females and males. That is a new thing. Historically, death rates from suicide have always been higher in males than in females. I should note that there has now been a dramatic divergence. In 2017 there were 25 males and only four females.

The Hon. GREG DONNELLY: Really.

Professor HAZELL: Yes. There are probably a few reasons for the convergence. One is that females are choosing different methods—methods that are more like their male counterparts. That would include railway suicide. Another possible reason is that females have been more likely, in the past, to suicide by poisoning. Our toxicology services are getting better and better at resuscitating and saving people who poison themselves. So, whereas people would previously have died from self-poisoning, now they survive.

The Hon. GREG DONNELLY: In the year 2009 there is an upwards spike. Is there anything to be read into that that you are aware of?

Professor HAZELL: I am not aware of anything specific that occurred in 2009 or the year before.

The Hon. GREG DONNELLY: I know that this is not represented in either the table or the graph, but if we go back in history to before 2002, were the numbers broadly the same or does the longer-term trend go one way or the other? Are there any insights that you can give us in regard to that?

Mr BARNES: I think the problem with going further back is that the data becomes less reliable. Suicide had a stigma. There were prohibitions against even making findings or publishing them.

The Hon. GREG DONNELLY: So we are talking about, roughly, the turn of the century. That was when we were starting to get some pretty good information.

Mr BARNES: In most places; yes.

The Hon. GREG DONNELLY: That is the general consensus, is it not?

Mr BARNES: That is right—yes.

The Hon. GREG DONNELLY: On page 19, my questions are in the same vein. Do you have any reflections or comments that would be worth passing on to us?

Professor HAZELL: No. There is variability in the data again, which was reflected in the previous graph. Overall, the death rate from suicide for people 15 years and under is substantially lower than it is for the 16 to 17 age band. If we were reporting data on 18- to 20-year-olds, or 20- to 25-year-olds, the rates would be higher still.

The Hon. PAUL GREEN: Are the numbers for the 17-year-olds muddled up with the Higher School Certificate [HSC] and the pressures of the HSC? Do you know of any findings for that?

Professor HAZELL: The Child Death Review Team [CDRT] data do not specifically analyse the data in terms of proximity to HSC. The increase in death rate from suicide extends through the HSC period, so there is not a spike at HSC that then drops off after the HSC.

The Hon. GREG DONNELLY: The year 2009 is interesting. If you follow the top graph it goes down, then up and down, and up. It is spiking in 2009. Then in the following years, 2010, 2011 and 2012, it continuously goes down before it starts to move back up again. It is very interesting.

The ACTING CHAIR: Mr Barnes, you are very interested in a suicide register. What does that look like? Does it just record the number of people or does it utilise material from police reports and coronial inquiries, for the purposes of the register, to connect the event with some circumstance?

Mr BARNES: The purpose of the register is to gather far more information than is available at any other source. The ABS simply records the fact of the medical cause of death—fall from height, drug overdose, asphyxiation—and the manner of death: intentionally self-inflicted external cause. A suicide register seeks to flesh out the picture and find as much as possible about the individuals—education history, medical history, previous self-harming episodes. It depends on how you design the register but the best one we have in Australia is the Queensland suicide register and the Australian Institute for Suicide Research and Prevention [AISRAP] at Griffith University. In partnership with the Coroner's Office there, they have access to not just the Coroner's records but all other linked medical records, police records and education records. Indeed, they have direct access to family members if the family members are willing to provide that. So it enables a much richer data field to be created around the individual deaths.

The ACTING CHAIR: In your previous role you were the Coroner in New South Wales.

Mr BARNES: One of the reasons I know so much about it in Queensland is that I was the Coroner up there.

The ACTING CHAIR: Yes, you were also the Queensland Coroner. One of the criticisms often is that in data collection there is a vast gap between the incident and the actual recording of the data. That is because the police do an investigation, collect the data and pass it on to the Coroner; then sometimes the Coroner will take as much as 12 or 18 months to issue a finding in relation to cause of death or whatever. How can we deal with that in a more expeditious way so that the data that we are getting is more reflective of what is occurring at any time? Do you do your investigations simultaneously with the Coroner, or after the Coroner?

Mr BARNES: Here we rely on the data being sent to us by the Coroner's Office. So we do get it in real time and we can make decisions about it before necessarily the Coroner has concluded. But the reports that we provide to the Parliament are necessarily after the coronial inquiries have been made. The two suicide registers that I have familiarity with are the Victorian register—which is in the office of the State Coroner there—and the Queensland suicide register at AISRAP. They both receive information in real time and start their data collection and data analysis before the Coroner concludes his or her findings.

They are able to do that because their publications are de-identified. They are making findings for a different purpose. It is not a legal finding, as the Coroner makes. Indeed, there might not necessarily be a direct correlation. I know that AISRAP or the Queensland suicide register also records what they call probable suicides, because they feel that if something has occurred that might have been a suicide then it is equally beneficial to consider it in those sorts of research contexts in a way that would not be appropriate in a public legal finding.

The ACTING CHAIR: In fact, the Hon. Paul Green gave the example of the Coroner faced with a motor vehicle accident where someone has driven into a tree, or whatever. The cause of death may be accidental or it may be suicide, in fact, depending on the circumstances. The register you envisage would include potentially those sorts of incidents?

Mr BARNES: Yes, certainly. We know from overseas studies that approximately 10 per cent of single vehicle accidents are intentionally self-inflicted. It would be very rare, for example, on the other hand, for a Coroner to make a finding that a single vehicle accident was the result. As Professor Hazell mentioned before, rural suicides are quite different from metropolitan deaths. That is a good example. A single tree beside a road, you cannot exclude the possibility that fatigue led the driver to go off the road, but there is a strong basis for suspecting that many of those are not being properly coded as self-inflicted.

The ACTING CHAIR: I am interested in this issue about the delay from the event to a finding by the Coroner. How can we expedite that?

Mr BARNES: Fund the coronial system appropriately. We have 6,000 reportable deaths in New South Wales each year; there are five full-time coroners.

The ACTING CHAIR: What, in your experience, is the delay between the event and the finding?

Mr BARNES: It is different case by case. If a matter goes to inquest, it will take a long time. If it is dispensed with, so dealt with on the papers, it will be much quicker. The Coroner has to wait for the police investigation, the autopsy report and the like, so there are lots of agencies involved. I know that in New South Wales the benchmark is 90 per cent within one year.

The ACTING CHAIR: Previously I have raised whether there is potentially an opportunity for having a specialist suicide coroner. Is that something you might support?

Mr BARNES: I cannot see a lot of benefit in that. They are a type of depth. More often than not, you are not simply focusing on whether the death is suicide, but you want to consider whether or not the health care provided to the deceased person was appropriate, whether emergency services responded appropriately to the incident. For that reason, the Coroner needs to be across the board in general coronial investigations. I am not sure we would get a lot of benefit.

The ACTING CHAIR: You have said that the best approach to expedite a system is additional resources?

Mr BARNES: Yes. If you look at funding comparatives of the coronial systems on the eastern seaboard, the other two States are spending twice as much as New South Wales.

The ACTING CHAIR: I will move on to one other observation you made. You questioned whether there should be a greater integrated system for prevention. Do I read you correctly?

Mr BARNES: That is correct.

The ACTING CHAIR: What do you mean by that? Do we have a plethora of services surrounding prevention issues which are not necessarily integrated or do not talk to each other enough to be able to deliver proper prevention services? What leads you to say that we need a better system of integrating prevention services?

Mr BARNES: Again, that is something Professor Hazell could speak to better. If I can give a couple of examples, we have good acute care. A child is taken to a provider of psychiatric services when they are deemed to be at risk to themselves or through self-harm and they generally receive good treatment in those facilities. They naturally, and understandably, should not be kept there longer than is judged necessary but they will be, in most cases, at some ongoing risk so we need to transfer their care from the inpatient treatment to the community treatment. We frequently see a failure to make that transition effective and integrated and coordinated. All the hospital service providers will record the fact that they have logged the case with a community mental health team and the protocols for both organisations will provide that there must be contact with the family and the child within a short period of time. That frequently does not happen.

The ACTING CHAIR: Would you like to comment on that?

Professor HAZELL: Yes. My opinion is that New South Wales should follow evidence-based strategies for preventing suicide. At the moment, the best and most coherent model is that being presented from Black Dog with the LifeSpan model, which outlines nine different approaches which work together. Their goal is to try to reduce the total number of suicides in New South Wales by 20 per cent, so it is an achievable goal. In my opinion, strategies should not be rolled out if there is no evidence to support them. What has happened historically is well intentioned. In response to a suicide or a number of suicide deaths people often will develop or offer an intervention. The risk is that the intervention could do harm as well as good. I will give an historical example which is from the United States.

In response to what appeared to be an upswing in student deaths in particular in the United States in the early 1990s, school-based suicide awareness and prevention programs started being developed and rolled out in a number of States. The analysis of the outcomes of that were that most people who received the program did not need it; they were fine. Unfortunately, those who carried risk tended to be made worse by the program rather than better. At the conclusion of the program, their attitudes to seeking help and their attitudes to disclosing their suicidality to others had deteriorated from the baseline. That is an example of rushing in with a program without thinking about it and without basing it on evidence. You might actually do more harm than good.

That is a long-winded way of saying that we probably do have too many programs at the moment that are badged to suicide prevention, probably reducing suicide deaths. It is a relatively remote outcome that they are looking at. They are probably looking at other outcomes that are meaningful but they are not directed to reducing suicide deaths. Unfortunately, the term "suicide prevention" then gets diluted.

The ACTING CHAIR: That is very helpful.

Mr MICHAEL JOHNSEN: It has been mentioned today, and Mr Barnes you specifically mentioned that you believe the current best register that is available is based in Queensland. How long has it been going?

Mr BARNES: It started in 1992. It started getting full coronial data about 2002.

Mr MICHAEL JOHNSEN: With the data and, therefore, the interpretation of the information that comes out of that, have we seen corresponding improvement in Queensland?

Mr BARNES: Not that I am aware of.

The Hon. GREG DONNELLY: Professor, you made reference in the answer you have just given to the Black Dog model. Without being controversial, we hear about other programs, particularly for young people, which are presented by those who have given evidence to this inquiry. Why did you nominate the Black Dog example? Is that understood as having a particular high standard or level of efficacy?

Professor HAZELL: No. The reason I am mentioning the Black Dog LifeSpan project in this context is that each of the nine initiatives that they propose have evidence to support them. On the whole, the evidence is not that suicide deaths have been reduced, but there is evidence—and it comes back to the Hon. Paul Green's issue—there is the link between self-harm and suicide, but at least these initiatives have reduced suicide ideation, so there is some evidence that they have an impact that may lower people's risk of suicide. That is the reason I endorse it.

The Hon. GREG DONNELLY: Research has been done in that space?

Professor HAZELL: Yes.

Mr BARNES: The other benefit of the LifeSpan program is that they are trying that in four of the 10 identified hotspots. So in a couple of years we will have really strong data to demonstrate whether that system's approach has worked.

The ACTING CHAIR: One of the issues that we have been interested in is the so-called contagion effect. In the work that you have done, is there such a condition as we have referred to as contagion or cluster effects relating to youth suicide, or are there other factors at play here that we are not dealing with?

Professor HAZELL: Contagion is one mechanism by which clusters can occur. A cluster is an aggregation in time, space and method of suicides that stands out as being unusual. Contagion is a mechanism so it is borrowed from infectious diseases terminology and it assumes that there is some characteristic, something that is transmitted from one person to another, that induces their suicidality. We see contagion in self-harming behaviour and so the places where we would observe it are in inpatient units or other aggregations of young people who already carry risk and the behaviour of one individual will influence the behaviour of others. So we will have an outbreak of self-harming behaviour.

Referring to contagion as a cause of suicides, that generally has been difficult to prove, although the narrative descriptions make it look as if contagion was probably a mechanism. For example, if you look at instances where there has been communication between young people who have both died from suicide, it looks as if the behaviour of one person has influenced the behaviour of others. How much this contributes to the overall number of deaths in New South Wales is not known, but in the United States of America it is thought to contribute to about one in 20 suicide deaths. We have had two instances that we know of of clusters of suicide in New South Wales in recent times. Whether contagion was the factor behind it or others we are still uncertain. The Child Death Review Team has commissioned an analysis, a review of suicide clusters which is in process at the moment and we hope to be able to report on that review later this year. It is being undertaken by the Australian Institute of Suicide Research in Queensland.

The ACTING CHAIR: In relation to clusters, are there prevention methods which should be used in circumstances where there is an identifiable cluster which are better than others?

Professor HAZELL: The best prevention of a suicide cluster is to prevent the first suicide. But one of the interventions that has certainly been promoted to try to prevent the onset of a cluster is postvention which is typically understood as an intervention rolled out to schools but it can be rolled out to other organisations which helps that organisation manage the immediate aftermath of a suicide death in a way that is less likely to create an environment where a further suicide could occur. So it is about managing information, managing the more high-risk individuals in the community, ensuring that there is not glorification of the suicide death and so forth. We do not know whether postvention does prevent clusters. There have been various attempts to try to analyse this but it is a hard thing to prove. But I was engaged in postvention and the evaluation of postvention back 20 years ago when I was working the Hunter.

The ACTING CHAIR: Do you think we do it well?

Professor HAZELL: The good thing about postvention in New South Wales is there has been adoption and a universal buy-in by the Department of Education. It has been on board on this for about 20 years. In recent times, Headspace has taken over the role of providing the postvention. The advantage of that is that we now have individuals who are specialised in the intervention and do it relatively often. In contrast, when I was doing postvention in the Hunter once or twice a year, I was not maintaining my skills, whereas the team from Headspace, because it is basically an ambulatory team—will go to wherever a suicide occurs. It is dealing with multiple instances per year.

Ms JODIE HARRISON: On the postvention issue, the Mental Health Commissioner has recommended that the Government consider developing postvention guidelines for school principals. Are you of that same view or do you think it is adequately dealt with at the moment?

Professor HAZELL: My response to that is that Headspace has already developed guidelines which are national guidelines for the way schools manage suicide. They are very coherent, very well written and very accessible.

Ms JODIE HARRISON: Do schools comply with the Headspace guidelines?

Professor HAZELL: I cannot respond to that. I do not know. But when I presented to Department of Education activities there has been generally enthusiastic consideration of the guidelines. I think principals generally find them helpful.

Ms JODIE HARRISON: Mr Barnes, in your written submission you refer to the need for an overarching whole-of-government suicide prevention framework. What is your view on who should lead that?

There has been criticism in some submissions about whether health is the right lead agency for the prevention of suicide.

Mr BARNES: You could obviously place it in health effectively; it is the key provider. The Mental Health Commission would also be an appropriate sponsor for the development of the program or the plan. It would have to be a collaborative effort. Justice Health and Juvenile Justice would need to be involved.

The Hon. PAUL GREEN: I come back to your comments about clusters and contagion. It is nonsensical that after the first suicide 200 plus students attend the funeral and a couple of months later another person within that group commits suicide, having seen all the heartbreak and grief at the funeral. Would you reflect on that? I am also interested in your comments about the suicide pacts. I have also heard about young males having a pact. Regardless of what happens at the funeral, they have a deal on the table that they will do the same thing. Will you comment on whether that affects the cluster situation?

Professor HAZELL: A suicide pact is a specific circumstance and a variation of a cluster because the suicides will occur at an aggregated time and place, and often method as well. In response to your observation why is it that young people having seen the grief and distress that arises out of a suicide death might still be suicidal or die from suicide, there are few things here. One is that my own research, now 20 years old, found that at least for the first six to nine months following suicide what you would expect is what actually happens. Suicidality in the close friends of people who die from suicide actually goes down. In contrast to when a young person self-harms, self-harming behaviour in their friends tends to increase. We can assume it is because of the devastating impact that the death has.

The other thing that my research demonstrated was that some of the most high-risk young people in, for example, a school are not the obvious grieving group. They are not the friends, the people who are very close to the person who died; they are isolated individuals who are somewhat disconnected from the rest of the school community who carry their risk, not closely identified with the person who died, but somehow that death triggers their behaviour.

Mr MICHAEL JOHNSEN: Professor, you said earlier that the team has identified a couple of clusters and you commissioned a study into that. What types of clusters are you looking into at this point of time? Is it geographic or demographic?

Professor HAZELL: The two clusters of which we are aware are both geographic and compressed in time. One of the limitations is that our remit stops at 18, so if the cluster involved people who are 18 and over then we miss that data. The review that we commissioned is not specifically about analysing the clusters within New South Wales. It is analysing the evidence for clusters in any new information that may come to light in terms of cluster prevention. Most of what is known about clusters has been known for a long time—at least 20 or 30 years—but the new factor that we are particularly curious about is the role of information and communication technology in social media because that has not greatly penetrated the scientific literature yet. We need help to find out whether there is a grey literature—research that is being reported in other settings but not yet published—that would help to inform us.

The ACTING CHAIR: Can I ask you about the make-up of the Child Death Review Team? Is it just the two of you? For example, one of the things Mr Johnsen is interested in is whether there is a child psychologist you would call upon to inform yourselves?

Mr BARNES: The committee itself comprises people from a number of relevant disciplines. We also have the benefit of input and advice from other experts as deemed necessary by the group. No, certainly it is not just the two of us. There are about 15 full-time members who are a mixture of medics, welfare workers and others involved in the field.

The ACTING CHAIR: Thank you very much for attending today. It has been a very informative session.

Mr BARNES: Thank you.

The ACTING CHAIR: We are very delighted that people like you do the work that you do. I must say it is very helpful.

Mr BARNES: Thank you. We wish the Committee all the best in its deliberations.

The ACTING CHAIR: Thank you. Just one more thing: If the Committee has further questions we want to raise and put in writing to you—

Mr BARNES: We would be very happy to provide any information we can.

The ACTING CHAIR: Thank you very much.

(The witnesses withdrew)

LUCINDA FRANCES BROGDEN, Co-Chair, National Mental Health Commission, affirmed and examined

CATHERINE LOUREY, Commissioner, New South Wales Mental Health Commission, affirmed and examined

The ACTING CHAIR: Thank you for attending. The Committee welcomes Ms Catherine Lourey, who is the Commissioner of the New South Wales Mental Health Commission, and Mrs Lucy Brogden from the National Mental Health Commission. I take it you have received a copy of the information pack about the conduct of these proceedings. We usually commence by asking in what capacity you appear before the Committee.

Ms LOUREY: I am Commissioner of the New South Wales Mental Health Commission.

Mrs BROGDEN: I am the Commissioner of the National Mental Health Commission.

The ACTING CHAIR: Do you wish to make an opening statement?

Ms LOUREY: Yes. Thank you for this opportunity to present to this inquiry into the Prevention of Youth Suicide in New South Wales. The Mental Health Commission of New South Wales consistently hears from young people and their families that appropriate services routinely are unavailable when the young person is experiencing a deterioration of their mental health. We hear of young teenagers who are involuntarily admitted to adult wards where they are frightened and isolated. We hear of desperate young people in country communities where specialist support is several hours drive away and there is no reliable internet through which to seek online support. We hear of young people who are discharged from hospital after self-harming without so much as a follow-up phone call. We hear of young people being turned away from services because they are too unwell or not unwell enough.

We also hear of failed and insufficient responses to bullying in which children choose to end their own lives rather than endure further torment. We also hear of the impact of suicide upon family, friends and those professionals who have been working with that young person. Suicide and suicide attempts always are devastating. The grief of losing a loved family member, friend or colleague often is compounded by additional regret and sometimes guilt that come from the death that could have been avoided. The death of a young person by suicide is an unbearable tragedy because of the loss of all their potential and with it often a loss of hope for the future. It casts a shadow into the lives of their siblings and their friends and into their broader community. We need to act urgently to ensure our mental health system and the systems of support around that person and around those families, and especially within schools, can promptly and proportionately respond to emerging mental health issues in young people to prevent them from becoming a crisis. We also need to build the resilience of families and communities so they have resources and capacity to draw on in tough times.

The New South Wales Government has a mental health strategic plan called Living Well. In that document the commission advocated for specialised suicide prevention responses that meet the diverse needs of vulnerable groups in our community, particularly young people. We also advocated for support for local community responses as well as statewide leadership on this issue and we recommended that agencies across the board—Commonwealth and State, front-line services and those working behind the scenes—take shared responsibility for reducing the terrible toll of suicide. We believe that suicide prevention is everyone's business. It is encouraging that most of the suicide -related recommendations in the Living Well: A Strategic Plan for Mental Health in NSW 2014-2024 are being implemented and that innovative new approaches also are being applied. In particular in New South Wales, the lifespan trial being undertaken by the Black Dog Institute in four New South Wales sites will start to give us new clear data on how much an impact we can have on the suicide rate when we make a concerted, coordinated and integrated effort to do things systematically across communities—such as, for example, assertively offering support after a suicide attempt and training gatekeepers to be alert to the suicide risk.

It is also heartening that communities themselves are finding their own ways to address youth suicide. The commission is investing, along with the Centre for Rural and Remote Mental Health, in identifying approaches to rural and regional towns that could potentially be successful elsewhere. These are initiatives like the Clarence Youth Action Group, which is based in and around Grafton and which has experienced a number of suicides of young people. The group to which I was privileged to present a special award last year in Mental Health Month empowers young community leaders to build their own supportive networks, promote creative activities and speak up for the resources that they need. This develops skills in advocacy and community organisation that they can draw upon during their lives. In this way their voices are important in how Grafton has been responding to the suicide rate. It has been important for themselves in their own recovery journeys and also in providing a clear link from their own community into the broader systems. Young people's voices are

therefore key. If we listen to them and learn what causes distress and what supports are most effective and most acceptable we will have the best chance to fight back against the tragedy of youth suicide.

For the commission's role, we are currently, on behalf of the New South Wales Government, developing a strategic framework for suicide prevention in New South Wales. This has been guided by a cross-government and cross-sector committee called the New South Wales Suicide Prevention Advisory Group. This group includes representatives from the youth focused ReachOut, headspace, the Butterfly Foundation, the Department of Education, the Department of Family and Community Services and has other agencies such as Premier and Cabinet and the national commission on that committee. As anticipated in Living Well, this framework will identify young people as a priority population and we will include in our consultations on developing the framework a concerted consultation with young people, especially those who have previously attempted suicide or have been bereaved by suicide. These consultations will occur over the coming months and will be in rural and metropolitan and regional locations.

It is my hope that the framework will give agencies and organisations across New South Wales, whatever their purpose and scale, a clear guide to positive action that they can take to promote resilience and prevent suicide. In doing this though, we must not forget the wider environment in which our children and young people are growing up. Education is competitive and stressful. Work is casual and insecure. Housing in some places is just plain impossible to reach. We must not work narrowly against the act of suicide while promoting a society that drives people to despair. When we say suicide is everyone's business, we must mean this, we must act upon this. I thank you for the opportunity to present to you today.

Mrs BROGDEN: The National Mental Health Commission appreciates the opportunity to speak on this important topic on the prevention of youth suicide in New South Wales. The purpose of the National Mental Health Commission is to provide insight and advice and evidence on ways to continuously improve Australia's mental health and suicide prevention systems and to act as a catalyst for change in achieving those improvements. The commission has played an ongoing role in monitoring and reporting suicide in Australia and we are well equipped to provide advice to government in support of improved outcomes in suicide prevention and, in addition, work collaboratively with a wider group of stakeholders to further enhance this capacity as necessary.

In 2014 the commission published a national review of mental health programs and services, including those related to suicide prevention entitled "Contributing Lives, Thriving Communities—Review of Mental Health Programmes and Services". The commission called for an improved approach to suicide prevention based on a more systemic, evidence-based approach through local planning and coordination. However, despite the increased suicide prevention services we see being commissioned at a local level, there continues to be fragmentation and limited services, including in relation to data collection and knowledge at the national level, State levels and regional levels.

In 2015 the Australia Government tasked the commission with providing the national advisory functions on suicide prevention, noting that it requires cross-sectorial and cross-agency input. The Australian Advisory Group for Suicide Prevention was convened in June 2016 to provide advice, expertise and strategic support on suicide prevention in Australia to the commission by identifying priorities and promoting action. Drawing on the experiences in the sector the advisory group emphasised the need to address key priority areas including data collection and knowledge exchange; building the capacity of the workforce, paid and unpaid; and improving the responsiveness of families, carers and the community. The commission welcomes the inclusion of suicide prevention into the Fifth National Mental Health and Suicide Prevention Plan, which now sees the establishment of two new suicide prevention governance groups: the Suicide Prevention Project Reference Group, and the Aboriginal and Torres Strait Islander Mental Health and Suicide Prevention Project Reference Group. These reference groups will be responsible for developing the national suicide prevention implementation strategy, a nationally agreed approach to suicide prevention in Australia.

Additionally, the fifth plan will require all governments to support primary health networks and local hospital networks to develop integrated, whole-of-community approaches to suicide prevention. Given the establishment of these two reference groups and the direction of suicide prevention based on a whole-of-community approach, the advisory group is no longer required and the commission has advised members that we will cease working and having input into the new national structures. As part of its new role in monitoring and reporting on the fifth plan, the National Mental Health Commission will continue to have oversight of suicide prevention outcomes, reporting on several indicators relating to suicide and self-harm data and progress being made by the newly established reference groups.

In our submission to this inquiry into prevention of suicide in New South Wales we identified a number of opportunities for improvements in suicide prevention outcomes. It is important to note these opportunities are

not isolated to New South Wales and are reflective of gaps across each jurisdiction. The commission advocates for a coordinated approach, working with local communities in planning and service delivery across sectors including health, community services, housing, employment and education; a consistent and agreed data collection method for suicide attempts and the support received prior to and following; increased efforts to identify and prevent suicide clusters, which are known to be more prevalent in young people; the prioritisation of after-care and postvention activities and programs; and suicide prevention activities and programs that are culturally informed and co-designed with people with lived experience of suicide and suicide bereavement.

Mr MICHAEL JOHNSEN: Thank you both for your presentation and attendance. A theme today has been around data collection and reporting. It has been mentioned that the Queensland register, of which I am sure you are aware, is regarded as the best form of data collection and reporting mechanism available. It has been going since 1992, so I am suspecting it is entering its sixteenth year. One would suspect that a reasonable amount of data has been collected over that time. In conjunction with that there has been a fairly significant increase in resources in training or postvention or all parts of this subject matter. Yet we are seeing increasing rates of suicide. We know that knowledge is power, but we do not seem to be using that power to have a positive outcome. What are we doing wrong?

Mrs BROGDEN: What are we doing wrong? How much time do we have? I really think it is about what more should we be doing that is right. We have a lot of evidence. It is about focusing on evidence-based interventions and funding those. Across New South Wales and Australia we have developed services historically. Part of change and responding to suicide is acknowledging that what we have done in the past is not getting the shift that we need. We do need to refocus. For such a large system response it really is around culture and leadership in this area.

When you look in New South Wales at the four LifeSpan trial sites, that really is about looking at culture and leadership within particular geographic areas and how different services can coordinate and integrate to use those evidence-based services. I think there is a lot of hope that we can have at the end of those trials to then bring that evidence to scale it up across New South Wales. We are on that journey but, of course, like in many of these things, when we keep looking at the data and we are not seeing the shifts that we want I think we need to get a lot more impatient.

My key message today in all of this is: Let us do what we know actually will work and save lives. We spend a lot of time trying to find a magic solution. If we are going to track data—I cannot tell you what the suicide rate is in my own community in New South Wales because we do not capture it—it comes with a two-year lag, and that is two years too late. Some committees across the State are doing this anecdotally—probably in breach of many regulations—keeping Excel spreadsheets to track the data and develop their own community-based intervention, but there is no formal mechanism for doing this. If your child or my child has measles that is notifiable, but there are no protocols for capturing the data we have around self-harm and suicide. It is a real gap to a rapid response situation, which is often what it takes. There is a contagion effect that we know is in place, but we have to do what is already in the guidelines and do it properly in terms of after care. I am prepared to share my own lived experience in this: My husband, as an adult, presented to an emergency department in a New South Wales hospital feeling suicidal and needing help. We have had no follow-up. We know that that follow-up care is fundamental to saving lives, and actually works. If we are not doing what we know works now, we are not going to find some magic solution down the track. I really would implore people to do what we know is working and do it well, and we will save lives.

Mr MICHAEL JOHNSEN: I have a belief, and I use the issue of domestic violence as an example, that the more we open up the discussion, and normalise the discussion, it will be a major step towards being able to help bring down suicide rate. Do you share that belief?

Mrs BROGDEN: I think the conversation is an important part. What we actually do see in our young people is that they do talk about these issues quite a lot. We are just not listening to the conversations they are having, and not responding in a timely measure. It is an important part of the issue but, and both our submissions talk to this, there is no one solution. We need to be empowering our kids in their schools, pathways to and from employment, pathways in and out of education, and safe housing. We have very much a housing first strategy—safe and stable accommodation is fundamental to the wellbeing of our young people and the wellbeing of our community. Then, being able to have a safe conversation and safe disclosure. Pathways to care around that are fundamental.

Ms LOUREY: In the conversations I have had with parents, and with young people themselves, I think they are open to have conversations, they want to have conversations, but they feel that they do not want to cause any further distress to that individual or increase that individual's risk. Sometimes they may want to step into that space but they are unsure about what to do. Of course, when they are in that place they are very

concerned about: Am I actually contributing to worsening the situation? Young people who want to help their friends and help their peers, as well as the parents and maybe their siblings. So I think there is very much a role there around providing resources that are acceptable and for people to understand that it is okay to say, "Are you okay?" Check in with people. That then leads to a conversation and then, perhaps, helping that person to seek the kind of care they need earlier.

The ACTING CHAIR: The Committee heard earlier today from someone who suggested that a lot of the services that are provided are accessed by people who do not need them. They gave anecdotal evidence about services provided in schools in the United States of America, which suggested that in circumstances where there had been outbreaks, and resourced schools with a lot more facilities, the people who accessed them were people who did not need them. How do we address that?

Ms LOUREY: That is interesting, because if we do take the whole community perspective it really is about educating and supporting people. I do not know whether that study was about people who were demonstrating illness or need, or whether it was people who were feeling distressed and suffering a whole lot of despair in their lives. I do not quite know what the definition was of people who did not need them. We do have to understand that suicide and suicidality is a trajectory. It is a course. It is almost like a journey that people experience. It may be that there might be people that the study may have said, or people may have said, do not require it, but you may actually be providing them with resources that they use five years down the track. This is the thing, we need that kind of evidence to understand where do we support people and where we can change those trajectories. It is an interesting observation that was made to the Committee, and probably one that requires a lot more thought.

The Hon. PAUL GREEN: I will come back to that. It is obvious that we cannot have a Headspace on every corner. I think our best resource is the peer-to-peer relationship. It is great to have knowledge but knowledge without love and relationship is dead. The key for these people who, as you say, are hungering to sing out and want someone to listen, is their peers. I think you are right in terms of the R U OK campaign. One of the best things about that is it is as non-judgemental a question as, "How are you going?" I believe in what the Government is doing with welfare workers in every school. Now you can have welfare workers in every school but you cannot have professional organisations everywhere in regional and rural areas. That is just not possible. Be we do have an effective network right throughout schools in this country called peers—peers that care and are able to minister or reach out to each other. Is it not a fact that we should really be empowering our teams to be the safety net for those people who are acutely ill, with these teams having a similar focus to that of welfare workers, and then moving these people up the chain to eventually get professional help? I do acknowledge that, sadly, on many occasions professional help is too far away in our rural areas but is not the first step, and the best opportunity, through peer support?

Mrs BROGDEN: I think peer support has an important role to play, and that is across the board. I would just caution that not all suicidal people are acutely unwell; it is not necessarily around a mental illness. We have to make sure that we keep the whole spectrum in line of sight across the board. One of the interesting things coming through in the early analysis around the lifespan trials is that there is a huge appetite for gatekeeper training. Just to clarify, in a working environment a gatekeeper is a negative concept. You do not want to have gatekeepers because they are seen as barriers. In suicide prevention vernacular, gatekeepers are people who are trained to understand the signs of potential suicidality and also to provide some support. We would say, and both our submissions talk to this, we never know where those touch points are going to happen so the more we can educate the community as a whole the better. We know that young people seek out their peers but we also know that they interact in many other places. It is important to get that good spread across the community—whether in sporting groups, service organisations, et cetera—so that people are well trained to look for the risk factors and provide the support, and pre-empt it as well. Sometimes we are a bit quick to put all the responsibility onto schools but our young people are in many other places, not just schools.

The Hon. PAUL GREEN: Peers share with peers. Looking around the table we do not have to go very far to realise that when we were 15, 16 or 17 years old, and maybe hitting the turps or doing whatever we were to try and download our stress, we still shared that with our peers. We did not go and find someone who was super trained. That was our time to show a bit of vulnerability but under the disguise that we were drunk or off our faces or whatever. You rightly say that not everyone is acutely mentally distressed and unhealthy. The point is that prevention is better than cure, as they say in nursing. We went through a system where we had the ISCEF programs going for permission notes, and I brought this up with the former Minister for Education, Mr Adrian Piccoli. We had kids trying to take their friends to maybe a Christian faith program because they could see their friend was hurting and not understanding life, or their family was breaking down or something in their world was breaking down, and you were trying to get a permission note from that kid's parents. When their world is breaking down you are not going to get anything from their parents.

They are drowning, and perhaps their friends have realised that and have suggested a program or have said that they will support that person, perhaps even with a prayer. The prayer might be the oxygen that the troubled young person is looking for to get their head above the water for a moment. Do we have too much red tape in place, when really we should be starting with the basics and training young people to say "Are you okay?", because that is the right way to go, and pointing them to which steps should be taken if their friends says, "No, I'm not okay"?

Ms LOUREY: That is very important, and I would support what Mrs Brogden has said. I was at a youth group that was convened by the Advocate for Children and Young People, a representative of which I believe will be speaking with you this afternoon. I asked this group of young individuals how they would support someone in their network who was suicidal. They said, "We want to, but we don't know what to do". I said, "If they broke their leg, would you know what to do?" "Oh, absolutely." I asked what they would do. "We'd stay with them, probably call an ambulance and then the ambulance would come and get them." I said, "Do you know how to take an x-ray?" "No." "Do you know how to do orthopaedic surgery?" "No." I said, "You could still help that person without having all of those specialist skills? Supporting someone who is feeling suicidal is really the same." I told them it was about helping someone to a point where they need further support and sharing that you are there to get them into that.

Peer support is good, but we need to support those peers so they understand and can step into that space and also so that the individual knows that they too can step into spaces to get that help. It does not always have to be left to the peers. When we look at our education system, we have young children who are very distressed in being at school. Sometimes it can be a bit of a contagion, it can be a group that is already under stress. You also have to respect that broader group of peers.

Mrs BROGDEN: Adding to that, historically schools and communities have been nervous about talking about suicide, because they think they might trigger someone by having a conversation. There is now good evidence that, in the general community, having that conversation is a safe thing to do and within schools it is a safe thing to do. But there is an element of cultural shift and knowledge sharing to give schools, particularly, the confidence to bring in some of that training and prevention support.

The Hon. PAUL GREEN: We had evidence to the contrary from Professor Hazell who said that telling everyone might not be the best way to go, because you might trigger someone who has not shown obvious signs of suicidal behaviour. You do not need to go that far; you really just need to stay with your friend through a difficult time. You do not need to discuss suicide, because they do not know how to deal with that. Highly skilled people know how to deal with suicidal behaviour, but the first part of triage is to stay with the person as long as you are not in danger yourself. We do not need all these resources; we are complicating things. We need to strategically place people at the right place.

Mrs BROGDEN: I was not suggesting you teach children the full gamut of what suicide is about.

The Hon. PAUL GREEN: I am clarifying that because we have just heard that evidence and you might not have been aware of it.

Mrs BROGDEN: You need to ensure that people know you are not triggering suicide if you ask the person if they are okay. We know that across-the-board people are nervous to ask that question, because they do not know what to do if someone says no. New South Wales has a fantastic tool in Conversations Matter, which is publicly available but not well utilised. The tool is around how to take the conversation further if someone says no and staying present with that person.

The Hon. PAUL GREEN: We have taken evidence about suicide registers. Please comment on those and why you think they are good or bad and whether we should recommend such a register.

Ms LOUREY: Obviously, we have to keep track of our suicide trends. We have to have timely information if we want to intervene early, especially with youth suicide. We have to have a key in our understanding of communities and how to plan responses appropriately. We know that the data needs to be verified through coroners processes, and that is not disputed. But I believe that communities know when someone has suicided, and they need to be empowered to respond to that. That means responding to support peers and the grief in that community, because we also know that people who are exposed to a suicide, in their own grief, also have a higher rate of suicide risk. It is not only around data to map, understand and intervene but also postvention for the community as well. Whether it is a register and requirements around how data is shared across government agencies and protocols around contributing to it, any improvement in the timeliness of the data we get can only be a good thing.

Mrs BROGDEN: Adding to that, we would like to see self-harm and suicide data collected together, because we are seeing that trajectory from the first presentations around self-harm to completed suicide

narrowing all the time. Dr Robinson is appearing before you this afternoon, and she is a world expert on these registers and data collection. The sooner we can capture these issues and identify young people at risk, the faster we can put the supports around them. Two years is two years too late for many young people.

Ms JODIE HARRISON: My question relates to Living Well: A Strategic Plan for Mental Health in NSW and its reference to the need for a New South Wales suicide prevention implementation plan. There is a national implementation plan and I understand from the New South Wales submission that there is a reluctance to develop an implementation plan and instead the agencies want a framework developed. Please comment on that and give us clarification on the difference between a framework and an implementation plan. Are we not being impatient enough about an implementation plan?

Ms LOUREY: I do not know whether I can comment on your use of the word "reluctance". I can say that over all of our communities—Commonwealth, State or local government—we do need to have a concerted and coordinated effort bringing the evidence to bear. The first step in having a coordinated implementation strategy is understanding what it is you want to implement. The suicide prevention framework we are developing is around establishing what those elements are so that New South Wales can have a cohesive strategy. That means that when you are coming to different funding schemes, you understand if they are coordinated and, if they are coordinated you should get a better outcome for those communities. I can outline to you the elements of the suicide prevention framework.

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

Ms JODIE HARRISON: Would you see an implementation plan coming after the framework?

Ms LOUREY: Yes, but I would have to say that the commission provides the advice to government and it is then up to the ministry and others to do the implementation plan, as they are the ones who bid to Treasury. But that would be the hope.

Ms JODIE HARRISON: Ms Brogden, how far down the road is the national implementation plan you have been talking about?

Mrs BROGDEN: We have only just had the COAG approval the last quarter of last year, and the new advisory group is meeting the first quarter of this year to get that up and running. But I think what we know from suicide prevention is that it is much better driven as a bottom-up, community-owned, community-driven strategy. We are the highest level; we are looking at the issues around data collection, data intervention, workforce capacity and capability issues. One of the classic things that we see is that if we create pathways to care and there is no-one working in those services, then we have really raised expectations that we cannot deliver on—and that is across the board.

You may be interested to know that in most pre-service training for mental health workers there is very little around suicide prevention training. Psychologists do one hour at best at suicide prevention training unless they are going down a clinical pathway; GPs, doctors, the same. Suicide prevention is a real afterthought in pre-service training. So the workforce capacity and capability is an important issue for us to look at across the board. I think you have got Reach Out here today. They did a study looking at workforce needs, and we have got about a 15-year time lag on the mental health workforce to deliver on the strategies that we would like to see in terms of best practice.

But I think it is really important that in terms of developing a framework—we say quite often that health is our weakest lever in suicide prevention. Our strongest levers are going to come from education, employment, community participation et cetera. So it is getting that message across. For example, I was reflecting the other day about registering children for sport. The $100 voucher is part of a suicide prevention program. The more that we can get our children engaged into activities, and not just sport—it would be good if things could be broader, but the greater we can get young people engaged in community across the board, that is suicide prevention; the more we can get people being able to take time out of school but to actually get back into school when they are well enough to do that, that is suicide prevention.

So it is a whole raft of issues. Giving people opportunities for employment is suicide prevention. Giving them a sense of hope in their community is suicide prevention. I think our generation is very good at pointing out everything that is wrong in our society, and when you think about how that is interpreted on young ears, I think that place called hope is an important message that our young people need to hear about and strive for.

The Hon. GREG DONNELLY: Both of you can answer this, if you can. In looking at data in Australia to endeavour to make some sense of trends, if one can, what would you say we can take as a starting point, going back in history, when we have quite good data, quality data, with respect to youth suicide?

Ms LOUREY: I should take that on notice as I am not a statistician.

The Hon. GREG DONNELLY: You are welcome to do so.

Ms LOUREY: But I would say we do have good data. There are elements of it that need improving. For me, in the role that I have, it is about looking at communities, and when we are looking at youth suicide we have to be mindful about how we report that and aggregate that data, meaning if you are looking at a community it might be five people have suicided, and that community may know those individuals. So it is around understanding that balance between what can be reported and what can be aggregated so that it is meaningful, because if suicide fluctuates, you might have five suicides in the community one year and nothing the next, and you could say "Wow, we've fixed suicide. We're down to one", but it could be one, two, three and then it could go up again. I think that is part of the broader understanding of suicide data, that it is not only about the quality and the timeliness, but, because it is a rare event, there are not a lot of figures on it. So we have to be mindful about how we report it and draw upon it to inform our work.

Mrs BROGDEN: I think you have either had the ABS or they are coming today.

The Hon. GREG DONNELLY: Yes, they have been.

Mrs BROGDEN: We have only been tracking our very young—below 13—for a few years. So it is difficult to get a good sense of that data. Historically, we know from the Coroners that the practice was at coronial level data for many years there was a reluctance to call a death of a young person suicide if that is what it was. That is not to say that you would ignore all that data, but you just need to be careful when you analyse it. But for all those reasons there is no reason that we do not start now. I think where we see good community activity at the moment, fortunately and unfortunately, is where they are capturing it unofficially and working on it. Because at the moment, most communities in New South Wales rely on data that is two years old and, as I said that is two years too late.

The Hon. GREG DONNELLY: What is an example of capturing it unofficially?

Mrs BROGDEN: Where you get groups, such as police, ambulance, the local Lifeline or the local suicide prevention group, maintaining a spreadsheet of what they are picking up on the ground.

The Hon. GREG DONNELLY: Do you say that is quite prevalent in New South Wales?

Mrs BROGDEN: No, it is patchy, but there are some communities that do that sort of thing and are able to then respond and come up with responses. But that is all off the radar and, to my mind, that is not an optimal way of tracking these issues and responding.

The ACTING CHAIR: We have taken up more time than we should, but it has been enlightening. I am grateful for the work that you do, it is terrific. Thank you for being here today. If we need to ask you any further questions and send you written questions, I take it you are happy to answer those?

Mrs BROGDEN: Yes.

Ms LOUREY: Indeed.

(The witnesses withdrew)

(Luncheon adjournment)

ANDREW JOHNSON, Advocate for Children and Young People, affirmed and examined

The ACTING CHAIR: The Committee will now hear from the Advocate for Children and Young People, Mr Andrew Johnson. Do you have any issues relating to the pack which is sent to witnesses?

Mr JOHNSON: No.

The ACTING CHAIR: Would you like to make an opening statement?

Mr JOHNSON: Yes. I would like to thank the Committee for the invitation to appear before this inquiry into the prevention of youth suicide in New South Wales. The wellbeing of children and young people is everyone's responsibility and I commend the Committee on holding this inquiry. The advancement of the safety, welfare and wellbeing of children and young people is central to the work of the Advocate for Children and Young People [ACYP]. The office promotes the principle that all children and young people are entitled to have a voice in the decisions that affect them.

Mental health is an important but complex issue affecting children and young people. I believe we have made significant progress as a society in our efforts to destigmatise it and this bears out in our research with children and young people—but it is also clear that we still have further work to do. If the Committee permits, I would like to briefly run through some of the work ACYP has undertaken recently in running consultations into mental health, bullying and youth suicide. As you all know, today's children are navigating a complex world. They face constant challenges, such as sexualisation of young people, increasing social media pressures, violence perpetrated against them and employment and housing affordability uncertainty. Yet, they remain optimistic and compassionate.

As raised with the Committee previously, children and young people tell us that the qualities of a good society are respect, equality, safety, support and inclusion. They feel the value of connection and emphasise the importance of friends and family. Community engagement and connection to culture was particularly important for Aboriginal children and young people. I commend the Committee on its hearing in November last year in Singleton, allowing Aboriginal and Torres Straight Islander people and related services the opportunity to appear before the hearing. Given what we have discovered in our regional consultations it is also very important that you heard from our citizens in regional New South Wales on this important issue.

As the Advocate for Children and Young People in New South Wales I am not a clinical expert in the area of mental health. What the ACYP team and I do is undertake primary consultation and research work with children and young people to understand a broad range of issues and to elicit from their suggestions for more effective and efficient policy. During the office's consultations with children and young people they told us that feeling respected by their schools, workplaces and communities, regardless of their age, gender or race, is important in making them feel welcome and included. Having a voice in decisions that affect them is continually raised in all of our consultations and is, of course, one of the major themes of the NSW Strategic Plan for Children and Young People. We heard from Aboriginal children and young people that connection to culture is fundamental and that wherever possible services should be delivered by Aboriginal owned and controlled organisations.

I will first inform the Committee of our most recent consultations and then present the findings from our consultations on bullying, mental health and homelessness. At the invitation of the office of the Minister for Education, in December last year I attended three schools on the Central Coast whose students had recently been affected by suicide. The voices of these students were reflective of much of what I have heard from other young people regarding mental health and wellbeing. They spoke about the need for greater awareness around their own mental health and wellbeing, with the aim to normalise help-seeking behaviour. They want to know what services are available to them prior to and at the moment of crisis. They want to be able to access services confidentially, outside of normal work hours and—at their suggestion—at a "one stop shop". They want to better understand how to support friends who may be in crisis. They want to be able to access supports in a range of ways, including face to face, online chats and text, and less so via the telephone.

Young people want information about services in accessible ways. They felt that there was so much information out there that it can be overwhelming for them. They often stated that they did not know where to start and what information to trust. They had some very specific recommendations. One was a plastic card—like a credit card in terms of form, not function–with services, websites and numbers on that card. Interestingly, they told us that it would be better to be plastic because that meant the adults around them were taking it seriously. If it were paper then it may be it was not being taken so seriously. Another was posters around schools and on the

back of toilet doors with services and numbers; and school visits from services—but do not just talk to them in assembly, talk to them in small groups, such as tutor or homeroom groups, because it was more personal. They felt that it was very hard to single yourself out in a large assembly to ask a question or to display help-seeking behaviour, but if it were in a smaller group they felt more comfortable to do so.

Young people also suggested chill-out spaces in schools where they can go if they need time out. These spaces need to be in carefully thought out locations. Young people feel that often the school counsellor's office could be in a better location so that everyone could not see them going in and leaving the school counsellor's office. They also suggested that there were better ways to be called for appointments, because students knew when a person was being called for an appointment. They thought that could be done in a more confidential, sensitive way. They also thought that it would be a good idea to be able to make appointments with counsellors online, so that they would not necessarily have to go face to face with other individuals in the school.

Children and young people suggested that they would like to spend more time learning about available services and spend time in lessons navigating the actual websites that exist. They wanted more open conversations in schools around mental health. Students suggested the idea of a dedicated mental health day where they could see all the websites, see all the services and they could navigate which were the services that were best tailored for them, their circumstances, or what their friends or family were going through. Young people do not like to open up about their problems to strangers. Many said that the school counsellors were not as well known to them as they could have been. They made the good suggestion that at the induction of starting school that they would have a short time period with the counsellor so that the counsellor could be seen as more accessible and available. Young people wanted their school counsellors to maintain their confidentiality. There was often confusion amongst young people about what was confidential and what was not confidential. Of course, they wanted to know more information about finding out how they can help their friends going through difficult times.

In all the consultations young people spoke about the need for greater awareness around young people's mental health and wellbeing. This was discussed in relation to mental health lessons in schools and the need to reduce stigma, although I think more importantly, normalising help-seeking behaviour. Young people also reported wanting more opportunities to talk about mental health and related issues with their peers and teachers in small groups, as this would reduce the feelings of stigma and shame that many still associate with poor mental health. Similarly, when support services had presented in school assemblies, as I was saying, they were reluctant to ask questions in a large group.

Earlier to the consultations that we held on the Central Coast, we undertook face-to-face consultations with 22 focus groups from around the State, both in Sydney and in regional locations—that was with children aged between eight and 18—and conducted a survey of 1,000 young people specifically focused on bullying. We asked questions about the frequency, type and impact of bullying as well as how they would respond to bullying and what actions should be taken to address bullying in educational institutions and workplaces. When asked what it is that adults do not understand, and what they wanted me to say back to adults what they did not understand, they talked about the cyclical and constant nature of bullying that happens to them in their generation, that it goes from the classroom to online, from online to the sportsground, from the sportsground back to the classroom, from the classroom to the shopping centre, and so on. Being listened to regarding a situation about bullying was one of the key recommendations that children and young people talked to us about in the face-to-face consultations. They often heard, "Just ignore them," or "sort it out yourself". This was a common thread that children and young people were telling us was not the solution or what they wanted from the adults around them.

The key recommendations in relation to the reduction of bullying were that children and young people wanted parents to be more involved in their lives and they wanted the stigma specifically about boys not talking about their emotions to be removed. That obviously came up in our consultations on the Central Coast. Teachers should also not show favouritism towards some students and they should intervene more often. We as a community should not pretend it is not happening. We should create a stop-bullying campaign and there should be more anti-bullying programs in schools. They talked about having consequences for the perpetrators. There should also be 24/7 helplines for children and young people. In a survey that backed up the 22 focus groups, 98 per cent of children and young people considered bullying a serious issue, and 38 per cent said that they themselves had been victims. Young females are more likely than young males to tell someone about a bullying problem. If children and young people do not tell, they said it was because they thought the bullying would get worse, that it would not help, that they were embarrassed, or they did not know who to approach.

In relation to mental health, in our consultations for the NSW Strategic Plan for Children and Young People we asked children and young people what were the major priorities. They reported that mental health support and awareness was the third most important priority for government attention. Mental health counselling

about school pressure and more mental health support services were also ranked very highly in consultation with more than 4,000 young people. The consultations also indicated that mental health services are working differently for children and young people depending on age. While 23 per cent of 18 to 24-year-olds stated that mental health services were working well, only 8 per cent of those aged 11 to 17 years felt that mental health services were working well for them.

In 2016, ACYP asked a representative sample of children and young people aged 12 to 24 years to rate their mental health. While the majority of children and young people, 79 per cent, rated their mental health as excellent, very good or good, one in five children and young people, 22 per cent, rated their mental health as just fair or poor. Young women were more likely to rate their mental health as fair, 21 per cent compared to 9 per cent. Those with a disability were more likely to rate their mental health as fair or poor, 48 per cent compared to 19 per cent.

In 2017, the Office of the Advocate for Children and Young People published a report stemming from our consultations with children and young people experiencing homelessness. Many of these children and young people have multiple vulnerabilities and are more likely than their peers to be engaged with the out-of-home care and the Juvenile Justice systems. The prevalence of violence, abuse, trauma and poor mental health is high among young people experiencing or at risk of homelessness. The experience of homeless children and young people gives a clear understanding that mental health and wellbeing is not something that can be targeted in isolation. Participants in our homelessness consultations spoke about the complex relationship between their mental health and wellbeing and their ability to access education, employment, social and emotional support, timely and appropriate health services and a sufficient income to transition out of homelessness. They told us that when children and young people are provided with the right supports at the right time for as long as they individually need them, they have the very best chance of successfully transitioning into adulthood and independence.

Our work suggests that we need a wider lens through which to address the mental health and wellbeing of children and young people if we are to understand why youth suicide continues. Any action that is taken must target the safety, welfare and wellbeing of children and young people from a community perspective. I believe we also need to continue working to better understand ways we can increase the resilience of children and young people.

In our most recent campaign—End Violence Against Children Now—children and young people wanted us to tell adults that violence makes them feel unsafe, scared, hurt, alone, depressed, powerless, betrayed and ashamed. They also asked us to get adults to stand up and say out loud that it is wrong. Children and young people said that violence causes trauma and long-lasting damage and can be inflicted by both their peers and adults. As members know, the first step in the campaign will be getting adults to say out loud that violence perpetrated against children and young people is wrong. Most critically, children and young people must be involved in the development of policies and practices that affect them. They must be included in the design, implementation and monitoring of all the programs that the Committee has heard about during this inquiry. Their insight into these issues is critical, and in my opinion significantly increases the likelihood of success.

The ACTING CHAIR: That was a comprehensive statement. In relation to the issue of confidentiality, there is often a conflict between an obligation to report and the desire of young people to maintain their conversations with a counsellor. How do we resolve that?

Mr JOHNSON: Of course, we were reporting what they were saying.

The ACTING CHAIR: I understand.

Mr JOHNSON: I think what is important—and we need to get better at it—is explaining the nature of privacy within those settings so that children and young people are clear before they enter into a conversation with a trusted adult or a person with mandatory reporting responsibilities that if they reveal they are experiencing harm or are at risk of harm the adult will have to disclose that information. In our consultations we talk about confidentiality, but we explain that if they reveal they are experiencing significant harm we will have to tell someone else. We need to do better at explaining to young people what that means. Children and young people are no different from other people and we may need to better understand the limits and the conflicts and where we need to be reporting what they are telling us. Making that clear to young people would be an important step.

The ACTING CHAIR: Often the problem is that the child who is at risk—and that should be disclosed to someone—may have to expose something about someone and the consequence could be serious. If there were confidentiality attached to the disclosure, they may be more prepared to talk about it and potentially have it resolved.

Mr JOHNSON: It is like informed consent so that young people know that when they are talking about their issues with a counsellor, for example, they know the extent of that relationship. As members have heard and seen, there are many great online resources for young people and parents providing information about what to do in that circumstance. As you know and have seen, they all say to children and young people, "Even if your friend says that they want to keep this quiet and confidential, the best thing you can do for your friend is to tell a trusted adult." It is about getting those messages out that if they really want to assist their friend, that may be one of the steps they need to take.

The ACTING CHAIR: I refer to the comprehensive recommendations you have made in respect of resources available to schools. Have you submitted those recommendations to the Department of Education for a response?

Mr JOHNSON: Yes. We have spoken to the office of the Minister for Education and we will be following up this week. As I said, that consultation was done very late in the year. We have had one discussion and we will be talking to them again this week, which is timely.

The ACTING CHAIR: Some of them are very practical recommendations. They appear to me to be easily implemented. We are talking about online booking systems, advertisements on the back of toilet doors and things like that. The department could respond to that quite quickly. We should be taking that into account and it is worthwhile.

Mr JOHNSON: Yes.

Mr MICHAEL JOHNSEN: The predominant discussion today has been about data and its collection. It was stated that Queensland probably has the model suicide register in Australia. You are probably aware of it; it has been operating since 1992. However, suicide rates have not been improving. Your submission refers to New South Wales initiatives, and we know both factually and anecdotally that more and more resources are being allocated to suicide prevention and so forth. Despite that, we are not seeing any significant decrease; in fact, you mention that the incidence of suicide is at its highest rate in 10 years. What are we doing wrong and what can we do better?

Mr JOHNSON: I think it is important to realise that there are many positive steps that are being taken. I take this opportunity to thank the Committee for playing an important role to talk about this issue. We can probably just talk about what we are hearing from children and young people and from their perspective and I think it would be around how do we make getting and receiving the information easier and simpler. How do we communicate it in a way that they are more likely to hear the information. The small life hacks that they are suggesting, things like a greater focus on the sense of wellbeing and being able to know the school counsellor, having a relationship with the school counsellor, understanding that some young people said to us, "I did not think I could go to the counsellor because I'm not seriously mentally ill". They may think that they have to wait. There are lots of good things happening. The next step is making the best use of the enormous resources that are out there, but putting children and young people at the forefront of that and saying: What is it that they need? What is it that they are calling for? That is about collating, making it simpler, using language that they understand.

Mr MICHAEL JOHNSEN: Are you aware of the Where There's A Will Foundation?

Mr JOHNSON: I am aware of it. I would not say I have in depth knowledge about it.

The Hon. PAUL GREEN: You spoke about reporting. Obviously if there are other issues they escalate to mandatory reporting for staff and principals. Where do you think youth suicide sits on that reporting scale? When does it get so serious that you have to be able to do something with it, as opposed to the other situation where you are saying the kids just want to build trust and they want confidentiality?

Mr JOHNSON: On the spectrum what we are saying is in the prevention space we need to have a sense of normalising help-seeking behaviour, so if things get serious they are already on the journey of understanding it is like we get a check-up from the doctor we should get a check-up from the counsellor or mental health professional. That is an important step to focus on. In combination of the two questions, maybe that is one of the gaps we can work on—doing more work on normalising help-seeking behaviour. I think everyone takes the risk of suicide incredibly seriously across all of the services, whether they be direct services or education services, whether they are public or private. Once again it is everybody getting clear concise pathways as to what people need to do in that circumstance.

First and foremost it is about giving children access to the information that they need. This is available in many spaces. When we did more in-depth focus groups with young people who had a relationship over time the Youth Advisory Counsel. I can challenge them a bit more because it is safe where we see them every six

weeks. I said, "What would you search if you were trying to help?" And they said, "It's really difficult". I typed into google, "I need help with a friend who is going through troubles", and website after website came up. There is somewhat of a block about where young people seek help. That is why in the interim step there is something important about collating all the great services in one location that they are aware of.

The Hon. PAUL GREEN: You talk about accessibility to psychologists. My understanding is that there is only one psychologist in a school, not 15. Quite often they are snowed under so the chaplain or other welfare workers take the capacity of the lesser load. Is that your experience, that there is a huge need for an increase in qualified psychologists?

Mr JOHNSON: I do not think I have the capability to talk about the particular degrees best suited for support for young people would be best for. I think part of this is the society where I think things are getting better as we are realising that we do need these kind of supports in schools and they are getting there. There is a major investment in that area. Like everything, does there need to be more? Yes. Can we do better? Yes. As this rolls out we will have a clearer indication, particularly in regional locations, about access to services and wait lists. That comes up from young people whether it is in schools or whether that service is outside schools. While it is a situation we need to improve it is also a sign that the message is getting out there that there is a culture of help-seeking behaviour. There are gaps in the system in terms of young people at the serious end about being able to get into mental health services. Particularly young people experiencing homelessness, children in out of home care and Aboriginal children.

I think we can do better at the interface at the emergency end, particularly for children and young people. In terms of more, then I think that is something as we are rolling the system out and getting more resources in this area it will not surprise you to hear from me that we have to involve children and ask is it working for them. Are you able to get in when you want to get in? Are they located in the right space? We are heading in the right direction. As you rightly point out there probably needs to be more assistance to help children and young people figure out where they need to go for help. What is their problem? Where are the online resources? How can we assist them to be agents in their own sense of wellbeing as well as having help-seeking behaviour about seeing a counsellor, psychologist, psychiatrist or youth worker?

The Hon. PAUL GREEN: You noted earlier the connection between the kids knowing who they are able to go to. If they do not have that relationship established it makes it hard to trust.

Mr JOHNSON: I have seen in a lot of submissions and international research about the use of the term gatekeeper. I think that is a good thing although we often say to children go and talk to a trusted adult who may not be the gatekeeper, who may not be at that moment the counsellor. That is why we need dedicated specific services. We also need ongoing training for those people working with children and young people about what you do in that circumstance because you may have developed an appropriate relationship with a young person that you work with who trusts you enough to raise specific issues. While we need specific and professional help in the area we also need to ensure, and it is happening, that the training of all people working with children and young people gives them the ability to know what to do when they are given that information.

The Hon. PAUL GREEN: It is the triage system. If it can be dealt with at the peer-to-peer level that is good, but if it needs to go up to the next speciality that exists they need to know that pathway.

Mr JOHNSON: And knowing that there is no stigma or shame in having a mental health check-up. One does not need to wait until what they think is a serious problem before talking about it.

The Hon. PAUL GREEN: I totally agree.

The ACTING CHAIR: You have identified young people seeking access to help. Often the best identifiers of kids who need help are their friends, or alternatively adults who say, "I have a kid who cannot get out of bed" or "I have someone who has stopped communicating". What are the services we are providing in relation to that cohort of people to have access to help and be able to talk to schools, counsellors or whoever for the purpose of saying, "I have a child who was a happy-go-lucky child and has now become very introverted". What do you say about that help?

Mr JOHNSON: I would say that same thing as I say about children and young people, it is about ensuring they do have a place where they can seek assistance. I think probably for parents it can be equally as confusing as there are so many resources out there, where do you go first? In the same way as we would say to children and young people it is important to talk to your school and your community and seek help. In understanding the situation, data is incredibly important, but a lot to do with children and young people is the change of culture—both within children and young people themselves, but also parents, guardians, teachers and social workers. They, too, are on the journey of understanding that seeking help is a positive pathway—that there is no stigma in doing so. Mental health is a common problem for many children and young people as it is

for adults. So it is breaking down those stigmas—focusing on people not feeling stigmatised or shamed about seeking that kind of help.

Obviously, digital resources are one part of that but it is showing that we are continuing on the pathway of cultural change about people understanding that, in their own world, it is a normal thing to do to say, "I need some help with understanding what is happening with the child or young person who is in my care."

Ms JODIE HARRISON: School counsellors are a valuable resource, and young people have said to you that it is important that they are approachable. I have heard of a barrier to young people approaching their school counsellor—that they do not want to be seen to be leaving their class. Is that something that young people have raised with you? How do we get around that, given the fact that school counsellors work in school hours?

Mr JOHNSON: There was the great suggestion by them, which was that if, when they start high school, part of their inductions would be to meet face to face with the counsellor. That would be in small groups or one on one depending on the capacity of the school and hours of the counsellor. A lot of them, if they did not have a problem, were going, "Do I need to go to them? Am I sick enough to go to the counsellor? Do I have a problem?" That is, in some ways, in their heads—in their own thinking about the problem—value worthy. So I think we need to break down the stigma about counsellors—that they are there for your mental health and wellbeing, not just if you are feeling "sick", which would be the word that they would use.

It is certainly an issue but once again I think that it is an issue for all human beings, including children and young people. Given that they are at the stage of life when peer approval is very important, that plays into whether they can feel as if they can single out. So we can do better at how children can approach and make appointments, and we can do better at normalising the role of the counsellor very early on with children and young people in their transition moments as they move from school to school.

The ACTING CHAIR: You make an observation that young people talk about access to drug and alcohol rehabilitation centres, and generally they are adult focused. That in itself becomes a bit of a barrier for accessing them because the children think, "That service is not for me." How do we change that? Is one of your recommendations that, in respect of those two issues, we have child centred drug and alcohol rehabilitation centres?

Mr JOHNSON: Yes, and we would say that that should be the case not just for those services. There has been recent investment in drug and alcohol rehabilitation centres. One of the important things to understand is that there are detox centres and rehabilitation centres, and they are quite different. You may not have been able to access a detox. If you have not gone through detox then you may not be able to enter a rehabilitation facility.

While we are seeing more investment in that area, which we welcome, of course there needs to be more—specifically in regional New South Wales and particularly for Aboriginal young people being taken off country a long way from family supports and structures. So I think there needs to be an emphasis on detox facilities specifically for children and young people, and also even more investment than is currently planned for rehabilitation.

The ACTING CHAIR: Are there different specialists for dealing with children as opposed to adults?

Mr JOHNSON: There are some. There is further investment in some more. So we are heading in the right direction. It is an issue that comes up a lot, particularly when we are listening to the kids who are doing the toughest of the tough. Children with multiple disadvantages who have suffered violence or trauma and may be experiencing homelessness may talk about finding services and also that the services that they find may not be appropriate for young people. A young woman who is needing services to deal with trauma and violence may assume that the services that are available are for women, which does not mean it is for her.

So there are two things. One is more investment in that area, and the other is a little bit of a change of language to say that these services are available for children and young people, because they are probably highly tuned to hear if they are included in the service. Part of the reason we always suggest that we talk to young people is that it is sometimes as simple as how you describe a service which could change young people's access to it.

Those people who are doing it very tough are always calling for youth specific services. When we talk to them when they are in those services we always ask them what is working well for them. They say, "The service is working holistically. They understand the many different problems I am facing. I was surrounded by other young people." For them that was an important part of being on the road to recovery from whatever different circumstance or disadvantage they were facing.

Ms JODIE HARRISON: Where are the youth specific detox centres in New South Wales?

Mr JOHNSON: I do not want to get it wrong so I may take that on notice and send it back to you in the next couple of days.

Ms JODIE HARRISON: I want to know about detox and rehabilitation, which are different.

Mr JOHNSON: They are quite different. In my chest infection fog, I feel that I might get it wrong. I think there has been some recent investment up north and in Sydney. I want to make sure that I am giving you the up-to-date list of those locations. They are often separate.

The ACTING CHAIR: One of the big factors in relation to young people is that sometimes the impact involves the Indigenous community. Do we have enough Indigenous counsellors and people from an Indigenous background providing that sort of one on one help?

Mr JOHNSON: When we have talked to Aboriginal children and young people across the states—we have heard back from over 1,000, with whom we have sat down with face to face—we have found that for them the overriding thing is that the people they are interacting with have a connection to culture, or that the services they are being provided have a connection to culture.

Interestingly, when we ask, "What is working well? Is there a good service you can talk about?" either we know straight away that is an Aboriginal owned and controlled services or we say, "We haven't heard of that one." Ninety-nine per cent of the time we will go back and search for the service name and find that it was an Aboriginal owned and controlled one. So I think it is very important that, as first principle, when we are working with the Aboriginal community as a whole, and specifically with Aboriginal children and young people, that our services are connected to culture and, wherever possible, run and provided by Aboriginal owned and controlled organisations.

The ACTING CHAIR: Are we resourcing that enough?

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

The ACTING CHAIR: Thank you for being with us today. As you have already indicated, if there are any additional questions for you, which we put on notice, I take it that you will be happy to answer those questions.

Mr JOHNSON: We will be very happy to.

(The witness withdrew)

JO ROBINSON, Senior Research Fellow, Orygen, affirmed and examined

VIVIENNE BROWN, Senior Policy Analyst, Orygen, sworn and examined

The ACTING CHAIR: Our practice is that we normally invite people to make an opening statement in respect of the evidence they are about to give. Do you wish to make an opening statement?

Dr ROBINSON: Yes, thank you. I lead the suicide prevention unit at Orygen. What we are acutely aware of at Orygen is that youth suicide rates have been continuing to increase in Australia and that has been the case for around 10 years. They are particularly increasing among young women. We know the rates of depression and anxiety appear to be increasing, particularly related to suicide rates or self-harm, so one of the things that we are seeing in respect of characterising the problem is that young women more frequently seek help or present for help to services than young males. These young women are presenting for help with depression and anxiety, particularly self-harm. From our experience from speaking with young people, they present to services and do not get an optimal response, so they do not receive evidence-based care and they often receive a stigmatising response, which encourages them not to seek help in the future.

We also know that those people are at an elevated risk of suicide going forward. We know from international data that around 15 per cent of people who take their own lives are presented to an emergency department in the year prior to that. We are missing a unique opportunity for providing help to people who are most at risk when they are seeking it. We also know that the risk of being part of a suicide cluster is greater among young people. That has led us to conclude that young people need a specific response when it comes to suicide prevention. What we need are policy documents that speak to the needs of young people which young people are involved in developing that promote seeking help and providing help that is going to be user-friendly and accessible to young people. Some of the unique opportunities that young people offer are their interactions with the education system. They are often having their first interaction with the health system, so we know the majority of mental health problems and self-harm onset during adolescence.

They are often presenting to health services and systems for the first time. We have a unique opportunity to respond well and save them the burden of ongoing mental ill health or re-representation. We also know that there is a very strong role for family and friends when it comes to young people. There is an opportunity for strengthening the care systems and support systems around them. Whilst we often worry that technology might be part of the problem with the wrong people we also very much see it as part of the solution, so that offers some unique opportunities for mental health treatment and support. I think there are opportunities there for intervention that we are possibly not capitalising on at the moment.

Mr MICHAEL JOHNSEN: In your submission you talk about suicide being the leading cause of death in young people in Australia. You also mention there has been substantial investments and efforts in suicide prevention in the past 10 years, yet we are seeing rates rise. We have heard a bit of a theme today about data and data collection. As this data collection gets better and we go on, you would think that we would be able to use that knowledge and give some power to it and reverse the rates as opposed to having rates increasing. Substantial increases in investments have occurred in all areas such as training, education—all sorts of areas. What is going wrong? Why are we making these huge increases in investments and not making any inroads?

Dr ROBINSON: It is a good question and it is one that is hard to answer otherwise I would be doing a better job.

The ACTING CHAIR: We probably would not be holding this inquiry.

Dr ROBINSON: That is correct. Suicide is a complex problem. You are right, we have seen a lot of government investment over recent years in suicide prevention. I do not think we have really seen—and I speak for Orygen—a particularly well thought through youth-friendly response. We would argue very strongly that a lot of the response in the investment we have seen is certainly making inroads in other sectors of the population. In fact, young people and the very elderly are the only population for whom suicide rates are increasing. I think we are doing something wrong. We are doing a better job with our middle ages but we are not particularly doing a great job for young people. Certainly the young people we have consulted with, when we look at the suicide prevention strategies and frameworks that exist around the country and around the world, we are not seeing the way they access or interact with the health system. I think we are missing opportunities when it comes to developing and delivering a youth-friendly response.

The other thing I would say is that we are not investing well in data collection and monitoring. We have a great system in terms of recording suicide deaths that occur. Thankfully, despite the fact that rates are

increasing, suicide is a relatively rare event at population level. One of the best indicators of suicides and whether we are making any inroads in suicide prevention is the use of self-harm data. At the moment we are not collecting that very well nationally. That does not really make us different from a lot of other countries. There are a few pockets of excellent practice. England is one, Ireland is one and there are a couple of pockets of good practice around the country. But we have not got a robust and reliable system for monitoring self-harm presentations to hospitals. That is where we think some opportunities lie in really understanding what is happening when it comes to self-harm presentations and how we might intervene.

Mr MICHAEL JOHNSEN: Where those pockets of self-harm data collection is taking place are you seeing a difference? Are you seeing a positive outcome?

Dr ROBINSON: For example, in northern New South Wales there is a toxicology monitoring system where they monitor presentations for self-poisoning. What they have seen, through interventions that they can layer on top of those, is a reduced rate of repetition of self-harm. They have also seen reductions in hospital stays, hospital costs and bed stays. The other thing that we have seen in international systems is improved treatment outcomes for people when they present to hospital systems where those monitoring systems are in place. If you look at the United Kingdom there are some good examples. For example, one of the things that these really robust monitoring systems have allowed them to do is identify gaps in treatment. They can characterise people who present and then they can characterise the treatment that people receive and that leads to improvement in treatment practices.

For example, they were able to look at where in-depth and robust psycho-social assessment was going on for people who self-harmed. So rather than people just getting triaged and sent home, potentially they were getting these kinds of in-depth collaborative psycho-social assessments and then what they saw there were reductions in re-presentations for self-harm and better treatment outcomes. So there is some evidence to suggest that better monitoring, better data collection systems can lead to improved practice and reduced adverse outcomes.

Mr MICHAEL JOHNSEN: Is the United Kingdom seeing a corresponding reduction in suicides?

Dr ROBINSON: It is too hard to unpick, really, whether those things lead to a reduction in suicide rates. What you can tell is whether it leads to better treatment outcomes for those individuals or reduced rates of repetition of self-harm presentations.

The ACTING CHAIR: One observation is that often people most at risk are the ones who have already attempted a self-harm incident. They can be treated for that incident and have a long period of counselling and then when they leave the follow-up is not sufficient. Is that your experience?

Dr ROBINSON: That is certainly our experience, yes.

The ACTING CHAIR: Is there a deficit in the provision of those follow-up services? Are they just random or not available? We seem to have lots of people who appear in this space. Certainly when we have the cluster effect they can all attend on a particular area to provide services. But you say we need more people who are looking after people after the event so to speak?

Dr ROBINSON: When people present to an emergency department with a self-harm or a suicide attempt incident I think it presents a unique opportunity to intervene. The majority of people who engage in self-harm or feel suicidal do not seek help, but when they do I think it presents us with an opportunity to intervene. They are the population who are probably at greatest risk of suicide. Unfortunately, what we see is too great a proportion of those people being turned away without adequate treatment or without being followed up assertively once they are back in the community.

Ms BROWN: I would also suggest that part of the issue is about not being clear on whose responsibility it necessarily is to follow up, in this case, the young person. Once they are discharged from the emergency department, we know a referral has been made, but whose responsibility is it to follow up and ensure that that young person then indeed went and sought help from the general practitioner or from a mental health service provider? I think some of those issues were picked up too as COAG was developing the fifth National Mental Health and Suicide Prevention Plan to be clear about who is responsible for follow-up care.

The ACTING CHAIR: Is that a work in progress?

Ms BROWN: The Fifth National Mental Health and Suicide Prevention Plan is certainly out but I think they are continuing to work on developing at a government level a clear understanding around responsibilities and roles for follow-up care.

The ACTING CHAIR: One of the observations you made was the increase in self-harm and attempted suicide by young women. Do you have a view about why that is happening?

Dr ROBINSON: Again it is really hard to unpick. These behaviours are complex. One of the problems is that we do not have really good robust monitoring of these problems so it is hard to really know. We know there is a strong relationship with depression and anxiety. We know that particularly for young people risk factors include things like adverse life events, stressful life events, relationship difficulties, difficulties in their friendship circles, pressures at school and all sorts of things. It is hard to unpick or really tease out what some of those kinds of key drivers are, I suppose, for those increases.

Ms JODIE HARRISON: The Committee has asked about follow-up after an event. In your answer you said that upon presentation to a hospital emergency department there is an inadequacy of response. Your submission also refers to alarmingly poor responses to young people presenting with self-harm. Will you provide an example of how alarming it is?

Dr ROBINSON: Unfortunately I can. We have developed a couple of reports at Orygen over the past couple of years, one that specifically looked at self-harm in young people and one that looked at suicide in young people. In doing that we convened some focus groups with young people who shared their experiences with us. We had young people who told us that they had been treated without pain relief, so they had been sutured without any form of pain relief or anaesthetic. The implication was that because they had done that to themselves the doctor was, I suspect, stigmatising and judgemental and not very compassionate in their treatment. We know of young people who had called emergency services and the emergency services presented at the home and pepper sprayed a young person in their own bedroom because they were self-harming.

We know that responses are not necessarily as compassionate as they could be and we certainly know that young people who present with self-harm are not necessarily receiving the level of care that you might expect in other forms of medicine. These are only some small examples from individual young people. It does not necessarily make a statement about what is happening across the country. These are specific examples but certainly the young people we spoke to were saying that they would not seek help from professional services again because of the responses that they had had. Actually now what they do is turn to their friends. So if they found that they had cut themselves too deeply they would then seek help from a friend and they suture each other, rather than seek help at our emergency departments.

The Hon. PAUL GREEN: One of the challenges in regional and rural areas where you do not have a huge amount of resources is pushing off the responsibility of who is really in charge as opposed to saying, "I do not want to burn our precious hours here." Some patients or clients will use up every resource. If an agency knows that client they tend to marginalise them. Is it about not burning hours or is it about truly saying whose responsibility it is?

Dr ROBINSON: It is. We certainly know that in some areas of the country resources are limited and are very precious. We also know that there are very negative and stigmatising attitudes to young people who engage in self-harm. There is probably an interplay of both of those factors going on, I would suggest. Evidence certainly suggests that there are some very negative attitudes towards these young people which we suspect is probably driving the treatment that they get. When that is kind of overlaid with a limited amount of resources or referral options and those sorts of things, what we have is the situation that we are seeing at the moment, which these young people have described to us, where they do not get the treatment that they need and they repeat engaging in self-harm. They have mental health concerns or problems and then they are just not being treated correctly by the system when there has been an opportunity to treat them and to provide them with the support that they need.

The Hon. PAUL GREEN: Secondary to that is that you have talked about the patient who may have been sprayed with capsicum spray. Is that right?

Dr ROBINSON: Yes, that is what they described to us.

The Hon. PAUL GREEN: But there are two sides to every story. Having dealt with acute psychotic people, I know that if that was acute psychosis that may have been appropriate behaviour by the person who is trying to arrest that situation. Do give some merit to that—that there are two sides to the story? Of course, with the answer to that question we come once again back to resources. An acute psychotic person needs much more resources than does a person who is just chronic and has had a lapse for a period and who just needs to get their caseworker back to reassure them and deal with the anxiety or whatever it is. There are two different scenarios.

Ms BROWN: Absolutely. I think our position as well would be that an emergency department is not the ideal place to have anyone feel that they have to get to that point to present for a mental health issue. That really is about making sure that their resources, the structure and the infrastructure are available in the

community to provide mental health care for people so they do not have to end up at a point at which a police officer has to respond to a mental health issue, or they have to go to an emergency department and be hospitalised.

The Hon. PAUL GREEN: Obviously, in rural and regional areas, sadly, the police become the mental health worker. The next minute, they have the person on the back of a paddy wagon as though they are a criminal and they are dragging them off to an acute clinic, wherever it may be—100-plus miles away. They cannot do anything about that.

Dr ROBINSON: Yes, absolutely, and that would not be an ideal scenario for anybody.

The ACTING CHAIR: You have spoken a bit about clusters. How do you define a cluster?

Dr ROBINSON: A suicide cluster is a group of suicides that are either more than what you would imagine statistically for that region or you would define a suicide cluster if a community perceives it is having a cluster and therefore it thinks it has a problem. I probably have not described that very well, but statistically often people think of clusters as three or more deaths, but it will depend on the population size of the area. It is a statistically significant increase in deaths compared to what you would expect normally per population, or if the community perceives it is having a problem.

The ACTING CHAIR: What services should we be providing in terms of the perception that there is a cluster effect? How does a response to a cluster differ for an individual incident?

Dr ROBINSON: The idea of putting in a response after someone has taken their own life, and particularly if a community perceives it is having a cluster, is really about minimising the risk of distress and anxiety as a result of the potential for a cluster to be emerging, and particularly to reduce the risk of further deaths. Really it is important to have it contained and community-wide response. Again, some recommendations have been made internationally and here at the national level around what a community service response would look like. It talks about things like having an emergency response team in place. Ideally that sort of team should be in place prior to the advent of a cluster, although that is unusual. You would have an emergency response team and that might be made up of the all sorts of different people.

In the case of a young person, it is representatives from emergency services, representatives from the health service, representatives from the education system and those sorts of things, and representatives from the media, ideally. You would have that whole team trained in suicide prevention response. Then what you would do is work with the whole community at different levels. For example, you would work with media around responsible reporting of the suicide death so did not increase the risk of contagion. You would work with the education system around providing supports and containment for young people in schools. You would work with the health system around potentially increasing supports for those people who are particularly close to the young person who died to minimise the risk of those young people being vulnerable. We know that young people are very vulnerable to suicide after they have been exposed to the suicide of another person.

You would want this very much whole-of-community response that involves training your community gatekeepers, as we often call them, around better identifying and supporting young people at risk. You might put some case detection mechanisms in place so you can actually go in and identify young people who are particularly vulnerable, and you might put a service response in for those people who are very affected by the death. But you would also be working with the media and people like that as well.

The ACTING CHAIR: How well are we doing it?

Dr ROBINSON: According to the research evidence, not very well; but, again, I think those sorts of interventions are complex. I think there is headspace school support which is out there and providing a school-based response to suicide clusters. I am sure they are doing a very good job. The evaluation that has come out from there has shown good things. These things are complex to evaluate and we do not always evaluate them very well. According to the research literature, those interventions that have been signed to provide a cluster response have not really been able to show much effect because they have not been evaluated very well. But again I would probably argue that I suspect there are pockets of good practice, but they are not necessarily reflected in the research literature.

The ACTING CHAIR: It can be resource-intensive, of course, can it not, certainly in regional areas but not necessarily because of the resources you need to throw at it?

Dr ROBINSON: Very much so.

The ACTING CHAIR: Internationally? If I was to compare the way that Australia and New South Wales do it to international jurisdictions, how do we rate in relation to international responses to a potential cluster?

Dr ROBINSON: Again, there has not been an awful lot of evaluation that has come from internationally, either. What I would say is that a little while ago—and I cannot remember how long ago it was, but some years ago—Australia developed toolkit for a community response plan for communities experiencing a suicide cluster. Prior to that the United States [US] developed one and subsequently the United Kingdom [UK] developed one. The UK is about to renew theirs. Those probably went a bit further than ours and that is probably the fact that it was just done more recently because it really started to talk about the role of media and social media a little bit more than any of the previous toolkits or response plans have gone. It is hard to evaluate, but in terms of documentation, we have a national response plan for suicide clusters that probably stands up against the others internationally.

The ACTING CHAIR: I am interested in your observation about the response in social media. In many respects, social media is unbridled. How do you develop a social media response in circumstances in which you have a prominent celebrity who potentially elicits a copycat type of reaction? How does responsible social media response to that?

Dr ROBINSON: It is very challenging. We are doing some work at the moment. We have been funded by the Commonwealth at the moment to do some work developing evidence-based guidelines for talking about suicide and social media for exactly that reason. At the moment it is a bit unbridled. We are all journalists in this era of social media. One of the things we have done is a very small amount of work with young people about educating them about safe communication about suicide online. Previously what we have got for the mainstream media are media guidelines, which are great for people like ABC journalists and so on because they can follow these guidelines and they generally find them useful resources. For social media, they do not work quite as well, but we are starting to develop some in partnership with a social media company and with young people around what evidence-based good practice would look like when it came to communicating about suicide online.

The approach then that we will really take is an educational approach where we are actually engaging young people and talking with young people about what safe communication looks and feels like. Generally, young people do not want to do the wrong thing. They want to do the right thing but they just do not know what it is and they are not necessarily very good at detecting what makes them feel good or bad online. It is really about helping them work out and understand what is helpful and unhelpful about the way they talk about suicide online and capitalising on that.

The ACTING CHAIR: There is a similar correlation between bullying online and how we educate in respect of what is my response to someone saying awful things about me in social media. Is that the same sort of problem? Is it just educational?

Dr ROBINSON: I think a big part of it is education, actually. I do not know that it is all education but I think there is a big part of it that is. It is really around talking with young people about making them recognise what makes them feels good and not good, and knowing what to do about it and how to sort of separate. A few years ago we did some work with some young people who had been bereaved by suicide some years before then. They set up a very elaborate Facebook memorial page for this young person and they were all very involved in it. We did some work with them around what that felt like and they said there were aspects of it that were very helpful. It really helped them with the grieving process and they had a sense of community around grieving for this young person and they were able to support each other and gain support from each other.

But they also said that there were times when it was unhelpful and somebody would come in and make a comment that was distressing to other people—without intending to necessarily, but it was distressing. We asked them what would they go back and say to their 13-year-old selves now in terms of the relationship with social media. They said they would listen to their parents about when to get off social media or when to put their phones way. That was quite insightful for us because actually young people do carry their phones around with them all the time and they do not necessarily know when that is helpful and unhelpful and know how to separate from it.

Ms JODIE HARRISON: In your submission you talked about some concerns you had about the draft national plan, particularly in relation to non-inclusion of all relevant agencies and poor alignment with State plans. Has the Fifth Plan that has been adopted now addressed those concerns?

Ms BROWN: Obviously, from when we produced this submission the draft plan became bigger and it incorporated suicide prevention as well. Obviously, suicide prevention is a really important component of any

national mental health plan, and State and Territory mental health plans as well. A lot of the feedback that we had heard from the sector even in developing our report around youth suicide prevention was that it is bigger than a mental health system, or a service response as well as a health system. You do need to take into account education, justice and a whole range of other policies, platforms and portfolios and it needs to work in a more coordinated way. There is a risk in positioning the suicide prevention plan within the mental health plan, which was essentially the responsibility of the mental health or health Ministers of each State and Territory, that you might miss some of those other systems that play an important role in delivering suicide prevention activities. The Fifth Plan has only fairly recently been launched and announced, so I am probably not in a position to comment on the effectiveness of the rollout of that because it is just beginning.

We made the comment in our submission about the importance for suicide prevention being positioned as a whole-of-government responsibility and sort of the levers that governments can look to like the New South Wales Government in positioning it potentially as a Premier's Priority so that the mandate is there to bring together all the different departments and portfolios so that they are able to articulate what role and responsibility they can play and then also be measured on that and have targets and accountabilities so that everyone is working together. Maybe going back to the first question, potentially that is where we have not seen the kinds of returns on the investment that has been made in the past because some of those activities have been quite piecemeal and a little bit here and a little bit there and it is not necessarily a coordinated effort.

Ms JODIE HARRISON: Is there anyone who is doing it right?

Dr ROBINSON: That is a good question. Probably the only State in the country that has a separate youth plan is Tasmania. We were involved in helping them develop that. There they were very keen, they recognised that youth suicide looks a bit different and youth suicide prevention needs to look a bit different than suicide prevention across the adult age range. They developed a State-based suicide prevention strategy with a youth implementation plan that sat alongside it or underneath it that really spoke to the needs of young people and talked about some of those areas or opportunities for youth suicide prevention that sometimes we miss when we look at it across the age range. Technology again is a good example of that. Historically anyway, certainly in all the State and Territory based plans that we have had across the country and also internationally, when we have talked about the role of media it was really around restricting or kind of giving guidance and resources for media around safe reporting. When we talked about technology it was really about the potential for harm and there was very little that really started to think about or dig into what the opportunities were for prevention through technology. That is a good example of where a youth plan would look a bit different from an adult plan probably.

Mr MICHAEL JOHNSEN: I will preface what I am about to say with the comment that I am a big believer that we should open up and normalise the discussion; not the issue but the discussion. You have made a number of comments around the social media aspect, for example, where dedicated pages have been set up. You have monitored participants on those pages and gone back and asked how they feel about comments that have been made and those sorts of things. We have guidelines for safe media reporting and we link it back to the contagion effect. We seem to be going around in circles with increased resources and investment. You tell me if you think there is any spark of reality to what I am thinking, but the one thing that keeps coming back to me is that we are too afraid to talk about it. In your view, should we have all the resources that we have, and possibly more, in training, education and everything else that goes with it underlying a far greater discussion and should we not be afraid to go out there and talk about and report incidences and/or cluster or contagion effects of youth suicide or any suicide? Is that the one thing that we are doing wrong as a society?

I liken it to domestic violence. In my view, the more you expose situations of domestic violence the less likely it is that a perpetrator will have power over a victim. If I can liken it to something like that; knowledge is power, education is more knowledge and so on. Is that a direction that we should be not afraid to look at?

Dr ROBINSON: I would say suicide and suicide-related behaviours are extremely complex. There is not one solution to the problem that we have and that would reverse the increasing trend that we are seeing. What we need to see is a whole raft of changes actually and, importantly, within how young people interface with the health system and how the health system interfaces back with young people. But I would agree with what you are saying in that as a community and a society we have been very nervous to talk openly about suicide. There is a significant stigma associated with suicide. What has happened in terms of the guidelines around how we talk about suicide in the media has made the media a little bit nervous about talking about it, although what we have seen since those guidelines were released in Australia is an increased number of reports and better quality reporting. The evidence sort of flies in the face of what we might perceive.

I do think that as a community we are nervous about having a conversation about suicide. I think people are very afraid of saying the wrong thing. People are scared of asking a young person if they feel suicidal because they are nervous of what the answer might be and that they will not be able to do the right thing. They are nervous of not knowing how to respond. What that means is that when young people feel suicidal they feel terribly isolated and alone and they do not have a language to use to seek help. What we need is to educate young people around how to speak openly about feeling suicidal and we need to educate ourselves as a community about how to ask the question safely and carefully and how to respond if a young person does disclose risk. We have done a little bit of research around this and found that when we have asked young people if they felt suicidal and how that felt to be asked that question they found it helpful and in all of the studies that we have done it has not led to increased risk.

We have done some work in the education setting with young people providing universal education around suicide risk and we were very careful about doing that. We assessed young people for suicide risk before they took part in the workshops and we assessed them again afterwards to make sure that we were not increasing risk. We found risk reduced over the course of doing the workshops and by asking young people, they found it helpful to be asked, they found it worthwhile to be asked. They were then able to be linked in with professional help when they needed it. What we were able to do was detect a significant proportion of young people who had engaged in suicidal thinking but had not sought help anywhere else. If we are empowered as a community to ask the question we will identify a whole raft of young people who are vulnerable who would not voluntarily seek help and we are then able to help them.

Mr MICHAEL JOHNSEN: Can we get access to some of that research?

Dr ROBINSON: Absolutely.

Mr MICHAEL JOHNSEN: That would be great. Thank you.

Ms JODIE HARRISON: What about talking publicly about a particular death by suicide or a cluster? Is it right to talk publicly about details?

Dr ROBINSON: The evidence suggests that it is better to avoid talking about details. We would avoid talking about things like the method of suicide or the location of suicide because they are the ingredients that appear to contribute to the contagion effect. The evidence certainly says to not sensationalise or glorify the death in any way in any type of media reporting because that could lead a young person to interpret it as a desirable outcome for a set of problems that they might have been experiencing.

Certainly talking about the complexity of suicide, reporting that suicide occurs and is a big public health problem, and doing that carefully, highlighting how complex it is and highlighting the relationship between suicide and mental health, and advocating for including messages of hope and advocating for help seeking, appear to have positive impacts. So the answer is that you have to be careful how you do it.

The ACTING CHAIR: It is very difficult to do that in regional areas. For example, if you have two or three suicides in a town it becomes part of the local discourse.

Mr MICHAEL JOHNSEN: Even more important, the conversation is allowed to be open and discussed because people are making assumptions about all sorts of things.

Dr ROBINSON: That is right. So part of a postvention response would include accurate reporting and dispelling of myths and rumours. That is really important. Often by the time suicide is reported in the media most people know about it anyway. Whether in a small community or a large city most people generally know because they are connected through social media and those sorts of things. If we as a community take leadership in how that conversation is had, and generate evidence about what is safe and good practice, then we can elevate the conversation and have a safe and helpful conversation, rather than a potentially unhelpful conversation.

Ms JODIE HARRISON: What are linked multi-centre sentinel systems?

Dr ROBINSON: That is the system I was talking about in England. We are trying to establish one here. In Victoria we have just obtained some funding to set up a multi-site monitoring system for self-harm. We have just received some money from the Victorian State Government to set up an emergency department monitoring systems for self-harm in four hospitals across Melbourne and one regional hospital. We are already collecting data research dollars in two other sites as well. At the moment we are collecting data on people who are currently presenting and have presented in the past. The idea of a real-time sentinel site would enable us to spot suicide attempt clusters as they are emerging. In the same way that you have other types of disease or public health sentinel systems, you would be able to spot a problem as it is occurring rather than two years later when somebody sits down and analyses the data. The idea of having a multi-site system is that you have got

bigger numbers so you are better powered to detect change, identify trends and those sorts of things, but it will also give you a strong epidemiological picture of what is occurring across the country.

In England they have sites in Oxford, Manchester and Bristol and they monitor self-harm presentations to all of the key hospitals in those sites. What that allows them to do is build up a strong picture of the epidemiology of self-harm presentations and how they link and relate to suicide rates—so if you are starting to see reductions in suicide attempts, then what you can map that to is changes in suicide rates. We cannot do that here yet, but we are in the process of trying to set something up. As I said, we have obtained a little bit of funding in Victoria to do some work. We have got colleagues here in New South Wales who have got a small pot of money to pilot something here at Westmead hospital and a couple of the other sites around Sydney. The idea is that we are proceeding as a collaborative and ultimately will be able to link our data and get a really strong picture of what is occurring here in parts of New South Wales compared to what is occurring in Victoria. That is the idea. But the idea of a sentinel system is that you can then do that in real time, so you can track trends as they are occurring. Part of a strong cluster response is monitoring those trends so that you can see if it looks like you have a problem with a suicide cluster emerging.

Ms JODIE HARRISON: You say in your submission that there is one happening in Newcastle as well. Who is involved in that?

Dr ROBINSON: That is in the Hunter—what is the hospital called?

Ms JODIE HARRISON: The John Hunter or the Mater hospital?

Dr ROBINSON: It is the Mater hospital I think. It is the toxicology unit. Professor Greg Carter runs the system. What they are able to do is to monitor all presentations in the emergency department for self-poisoning—they have been doing that for multiple years actually. That data they have mapped on bed stays and costs and found a reduction. They admit everybody that comes to toxicology unit for deliberate self-poisoning. What they have found is that that links to a reduction in bed days in terms of hospital stays, rather than what you might imagine which would be an increase. We are working with them as well. The idea is that we will have this little network system at the Hunter, here in Sydney, in Melbourne and other parts of Victoria, and we are hoping to set something up in Tasmania as well.

The ACTING CHAIR: Thank you. Your contribution has been very informative. If the Committee has any additional questions would be happy to provide us with a response in writing?

Dr ROBINSON: Of course.

(The witnesses withdrew)

(Short adjournment)

JONATHON NICHOLAS, Chief Executive Officer, Reach Out Australia, affirmed and examined

KERRIE BUHAGIAR, Director of Service Delivery, Reach Out Australia, sworn and examined

The ACTING CHAIR: I welcome Mr Nicholas and Dr Buhagiar to this hearing. I take it you have received the information packs from the Committee secretariat. Do you have any questions arising from that?

Dr BUHAGIAR: No.

The ACTING CHAIR: Would either of you like to make an opening statement?

Mr NICHOLAS: I do. First, thank you for the opportunity to appear before you today. As I am sure you have heard from many people appearing before this Committee, the area of greatest concern for us at Reach Out is that suicide continues to be the leading cause of death among young people in New South Wales and, in fact, across Australia. Australia has made significant efforts in this area, and we have a lot of cause for hope. But more than anything—and I say this as a father of three young boys under the age of nine—the fact that the number one reason why I would lose my boys as young people still being suicide is a difficult thing for all of us here and certainly for those of us working in this area. The work of ReachOut has been for 20 years how we can use technology and digital media to improve the mental health of young people—in fact, we were the first digital mental health service when we launched 20 years ago. It now presents some very significant opportunities to address this issue, but broadly address the mental health of young people, particularly in reaching young people and their parents directly and indirectly.

The ACTING CHAIR: Please give us a brief outline of how your digital platform is used to engage young people.

Dr BUHAGIAR: The ReachOut Australia website is focused on the area of prevention and early intervention for mental health issues. Because of the nature of what we do, obviously, there are a large number of young people that access our programs and services that indicate that they are suicidal. The types of programs that we offer are around psycho education, so information for young people to help them to understand more about what they are going through and the next steps that they can take in terms of the help that they need for the issues that they are going through. We also develop a whole range of digital support and tools, things like navigation, to help young people to find their way to services, and self-help tools where they can learn to manage the issues that they are going through and respond appropriately and early. What we find with our programs is that young people are accessing them when other services are not open, so evenings, weekends and those sorts of times, so that they can respond immediately.

The ACTING CHAIR: Please give us the numbers of people visiting your site.

Dr BUHAGIAR: It is probably the most highly accessed youth mental health service in Australia. We have about 135,000 people. While we target young people between the ages of 14 and 25, we occasionally have parents, teachers and other community members access the service every month. As I said, most of that visitation occurs outside of ordinary hours, when traditional face-to-face services are closed to the public.

The ACTING CHAIR: What is the experience of a person who accesses your site? How does your site work?

Dr BUHAGIAR: There are a number of different ways that young people can access our service. Quite often young people access us through a general online search. We know that when young people are in high levels of distress, the first places they might go are to their family or their friends. Other than that, they very often go online. The benefits that young people tell us about online services is the anonymity and privacy, so they do not necessarily want to expose themselves and the distress they are going through to people they know or do not know, in particular. Quite often they go online to have a look at what sorts of supports are available and what they can do to self-manage the issues they are going through. When they come to ReachOut, they will quite often find information to help them recognise what is going on for them. Quite often young people tell us that they are very confused and they know that they are distressed, but they do not necessarily know what it means to them and if there are other young people who are experiencing similar things to themselves.

We have a lot of things like personal stories that young people can read about other people's experiences and see how they resonate with their own experience, so they feel more comfortable talking about what they are going through. We also have peer support forums, which are online. That provides a safe and supportive environment where young people can have conversations with each other about what they are going through. We have some ReachOut staff moderating those forums, and we also have young volunteers that are on

those forums to model the behaviours that we want to see on the forums and to escalate to staff if there are any serious incidents or concerns that arise. We find that young people are much more likely to disclose what is going on when they can do that in an environment where there are other young people they can talk to. The processes that we have in place are such that ReachOut volunteers and staff, if required, can help young people to identify where they can go and get help and what are the next steps to that they can take if there is a crisis situation or something that is very concerning to them.

As well as psycho education and peer support we have a range of digital tools. For example, one of the things that young people tell us is that it is actually quite hard for them to know where to go and what they can do about issues that are concerning them. Over a third of young people that access ReachOut are experiencing depression or anxiety, and we know that they are often precursors to suicide, suicidal behaviours or ideation. We can help young people to identify what is going on for them and how much it is affecting their lives, and what they can to next. They can identify which services they can contact in order to get some support and help for their issues, and we make that really easy for them in terms of linking them directly either to a telephone line, to a web service or something like that. One of the most important aspects of that is that young people are constantly telling us that they want to have a sense of control and a sense of autonomy in terms of the way that they access help, when they access help and how they access help. We find that by giving them the tools to navigate some of that themselves and stepping in to make that process really easy in terms of the next steps they can take, we play a very important role in helping young people identify what is going on and then taking the next steps and accessing the right type of support that is going to be best for them.

The ACTING CHAIR: Referring to the services you can connect them with when you have identified that they are facing an issue, are those services available in regional and remote areas?

Dr BUHAGIAR: The beauty of online is that there are no boundaries and young people, provided they have an internet connection—and now 98 or 99 per cent of homes have an internet connection—or a young person has a smart phone in their pocket, those barriers and the divide are broken down in terms of accessing services that are perhaps not available in rural and regional areas. In terms of the access to our services, at the moment it more or less maps to the population. There are a large number of young people in rural and remote areas that access retail services. Another thing we know is that the benefit of online services in those areas is the anonymity and privacy that I mentioned before, particularly when they are close-knit communities and young people do not necessarily want to be seen walking in the front door of a traditional mental health service or having their family know what they are accessing. There are a lot of benefits in terms of the services that we are offering, and we know that young people are using them.

Mr MICHAEL JOHNSEN: Are you able to provide data on usage by postcode?

Mr NICHOLAS: Yes, that is one of the great areas of granularity. We do not track people individually, but you can certainly get a sense through IP address. For example, we know that out of the 132,000-plus young people who access ReachOut a month, 36 per cent will come from New South Wales. New South Wales is overrepresented relative to population. We can get down to a fairly granular level. The same can be true for marketing, interestingly enough. One of the great opportunities with digital services is that we can dynamically market through, for example, *Facebook* down to a postcode and therefore respond if an issue emerges at a community level, or at an issue level. Recently, we saw the tragic suicide of a young woman in the Northern Territory. A lot of young people access ReachOut because they have concerns around bullying, but we can also dynamically target not only an area but an issue to pick up the most relevant things for young people.

Mr MICHAEL JOHNSEN: Can you provide further information if we have further questions that you take on notice?

Mr NICHOLAS: Absolutely.

Mr MICHAEL JOHNSEN: Is it possible for us to obtain some sort of report based on postcodes, and if you could break it up into—funnily enough, we use electorates—or local government areas or something like that, and possibly where the usage is across the State and whether or not there have been referrals as a result of that? Are you able to do that?

Mr NICHOLAS: Referral pathways is an interesting challenge. We have a tool called ReachOut NextStep that allows young people, or in fact anyone, to navigate the types of service options dependent on the issues that they are experiencing in the level of distress and reach those services. What we do not track is the click through to then reach the service, and that is for very good reasons. Most of those service contacts are by phone or people walking through the doors, rather than a digital access point. What we do know in terms of the digital connections is that ReachOut would be one of the major referrers to services like Headspace, for example. So when you, in a sense, backward engineer their journey, quite often ReachOut is playing a role.

The ACTING CHAIR: So Headspace is telling you that people have contacted it because they have been to you first?

Mr NICHOLAS: Absolutely.

Dr BUHAGIAR: And they do tell us that we are one of the highest referrers to most of the online services.

The ACTING CHAIR: Referring to monitoring the chat rooms and the forums that you are engaged in, what are the issues that are most prevalent in causing people to want to access you in the first place? They are not coming to you, are they—or they may be—to say, "I am feeling anxious and I am thinking of suicide", or are they talking about other things like, "My life is shit because I am being bullied every day at school"? Is that the level—

Mr NICHOLAS: It is a combination of both actually. The number of suicidal young people accessing ReachOut each month nationally would be probably about 39,000. They are not necessarily all coming in disclosing suicidal behaviour. Quite often, as you said, they will come in for a secondary reason or multiple reasons, and yet when you are able to unpack that through research, certainly they are very, very distressed. The other thing is that the distress that those young people are feeling and a high level of suicidality may, in fact, be very, very time limited, and we see this as one of the big benefits of digital services. A good example is that we know the proportion of young people who are suicidal goes up from August to December and exams—exams stress is not an uncommon reason why young people would become more distressed. By definition, that is a time-limited risk. Once you get to November you kind of roll on.

The ACTING CHAIR: The results are worse, let me tell you.

Mr NICHOLAS: Then you have another issue as you get into Christmas and we move on. But it means we can target our resources and services to provide extra support around the issues that they might be experiencing at that particular time. A good example of that is we saw a 40 per cent increase in the number of young people accessing ReachOut who were LGBTI during the recent national conversation. We are on the record of that with our colleagues. Again, that was both because the experience of discrimination and harm for them was predominantly online; it was not necessarily that they were being physically assaulted, but their experiences online were, by and large, safe. The access to support, as Dr Buhagiar said, was also safe and online. So it made sense that we saw a great growth in service access whereas perhaps other services did not see that.

So again, we are seeing some of those issues start to emerge where some are certainly to do with ongoing issues—"I'm having difficulties at home", "I'm having difficulties at school"—and some are what we would see as time-limited issues where there might be scenarios causing extreme distress. One of the opportunities that digital services play in this space is that you can use them to very, very quickly, and at relatively low cost, scale up support either in a region or by an issue without having the time that it takes to, for example, scale up a face-to-face set of services or telephone services. We can dynamically meet a demand and if that demand, for whatever reason, shifts we can manage that.

Certainly that has been one of the arguments we have been making, that the key challenge of the mental health system is it is incredibly inflexible; it is very, very limited supply relative to the demand, and the model is not flexible. So when you need to really pump out resources and provide intensive support, the system, even if it wants to, just cannot do that. We certainly see that in other areas of Australian life where they have taken advantage of the saleable nature of digital and use that to support parts of your other community infrastructure that can provide more ongoing, consistent help—they cannot scale up and down very quickly.

The ACTING CHAIR: Where do you get the people from who are monitoring the chat rooms?

Dr BUHAGIAR: A lot of them are people that are connected with ReachOut in different ways.

The ACTING CHAIR: Are they volunteers?

Dr BUHAGIAR: Yes, they are volunteers. They commit to two hours a week in terms of monitoring the volunteers, and we are very clear in terms of the extent of that role. The staff will handle anything in terms of prices or concerns and issues like that. The young volunteers are really there to model the behaviours that we want to see on the forums to make sure that the conversations are positive and constructive, and then to escalate to staff if there has been anything that does need—

The ACTING CHAIR: What training do you give them?

Dr BUHAGIAR: Each year we bring them into the organisation for a weekend and we spend three days with them in terms of training around the technical aspects of the role as well as self-care and boundaries

and all sorts of things. Then throughout the year we will do more informal training and then we will support them with our community manager, who will give them one-on-one support as well. So they are very well connected with the organisation.

The ACTING CHAIR: And numerically—

Dr BUHAGIAR: There are 20 each year, and usually by the end of the year there is some attrition, given that often things crop up that young people are not expecting, but we train 20 every year.

Mr NICHOLAS: That peer support forum plays a critical role in the many young people who have ongoing and, in many cases, positive interactions at a clinical level, but the nature of the difficulties are both persistent and episodic in severity. What those young people will quite often report to us is that if they are, for example, experiencing quite severe depression and have for some time, experiencing continuous suicidality, at some point they do not want to tell everyone at school that they continue to feel suicidal; they may feel comfortable telling their clinician, but that is one hour a week at best. So what do you with the rest of your life? Where do you go to provide that safe support?

So for those young people who are getting ongoing clinical need but their issues are very, very difficult, coming online into a safe, peer support community where you can disclose things that you cannot otherwise disclose and have those issues very well managed and dealt with, means that we can provide a lot of informal support and quite often keep that young person in clinical care because they are getting that non-clinical support. Increasingly, young people like that; they spend a lot of their time online, and being able to access a safe online community, as Kerrie said, particularly if you are from a rural community, being able to talk to other young people outside your community can keep you safe and well.

Dr BUHAGIAR: The other thing I would add to that is the role that the forums play in terms of crisis and distress. We also have areas on forums that are really focused on wellbeing and building those protective factors and skills that young people can use to keep themselves well. So it plays a really important part in terms of not just at that point of crisis or that point of distress, but it actually helps with that recovery process as well and helps keep young people well.

The ACTING CHAIR: Where do you get your funding?

Mr NICHOLAS: We get roughly 56 per cent of our funding from the Federal Government. We have two major contracts, one with the Department of Health for our youth service and one with the Department of Social Services for our parent service—we have not spoken a lot about the important role that our parents online service plays in supporting young people who are suicidal. The remaining comes from private investment. At this stage, we have had no consistent funding from State governments.

The Hon. PAUL GREEN: Your website is very impressive. It is very reassuring to read some of the parents stuff—it is very good. What can we do to basically give opportunities to such applications to make sure that we are getting that to kids, because I always say that it is not in the classroom necessarily; it is when your kids come home—I have six—and they shut the door and you are out of their world and they are into cyberworld, and that is where a lot of cyber bullying obviously happens? How can we get that sort of stuff? Because out in rural and regional areas where we are suffering from resource need, that is great, because that gets in the bedroom where they are.

Mr NICHOLAS: I think it is a great question. What is the biggest challenge today? It is not the choice between services, it is the choice between getting nothing and something. One of the things that we have been able to do through ReachOut is ensure that when a young person or a parent is in distress they can get through to ReachOut 24 hours a day without any service constraints. The challenge for us is one of continuity of scale. In the last 12 months we reached 1.6 million Australians through the site. We anticipate that with the right resource investment we can help another one million Australians in the year 2020. We see that there is a real opportunity for further reach, to your point where the kids are in the bedroom and the risks are online.

The other challenge that we see is smoothing out the pathways to further support. Our evidence shows—and we put it in our submission—that roughly one in two young people who come to ReachOut experiencing distress have alleviation of their distress. They get better—not necessarily always well—but they certainly get better. That means one in two do not. The question for us is: How can we most efficiently and effectively move those young people on to further services? That is really about better integrating the digital world with the offline world, so that a young person in a rural area we can geolocate using mobile data so that it only pops up with services if you live in Griffith. But we actually need the mapping of those services at a local health district [LHD] level so that we know where that young person can go.

The same as the pathways out. One of the things we have often thought about is that people's journey almost ends with a clinician, whereas almost anyone will tell you when they have been suicidal, actually that is where their journey to recovery starts. Better integrating digital services while the young person is getting clinical help is the real challenge. The point that we have quite often made to State governments is that ReachOut, because of its digital nature, effectively that investment from the Commonwealth and our private investors is a sunk cost. It is really about the cost now of making sure that tool gets to as many young people as we can. The cost of doing so is roughly about $10 per person we get to access. It really goes to demand.

The Hon. PAUL GREEN: What is the vehicle you use to get that to the student? Last year I visited Red Frogs Australia for schoolies at Byron Bay and Queensland. I know the Queensland Government supports the Red Frogs people going into schools, and they simply brand the number. Kids at schoolies ring in that number, whether it be for pancakes, an ear to listen to them, or anything. They are using the number because prior to schoolies week they have had presentations at school where the number has been provided. They put it in their mobile phone and nine months later when they are at schoolies they are ringing that number for the pancakes or to have their hotel room cleaned up, or whatever. It seems to me the key is that we have all the targets there in our schools. All we have to do is give them the information and constantly reinforce, "This is the number that you can ring if you are in trouble."

Mr NICHOLAS: Schools are certainly a critical part of our strategy as well—big, national and scalable. We are focused on building and developing evidence-based curriculum so that the teachers have the freedom to teach and integrate ReachOut in a way that makes most sense for their school. All of that is free online on the ReachOut schools website. The other thing that we see with young people in distress is quite often they do not think they will ever go through that distress up until the point they are really deep in it. One of the challenges that you face around, for example, marketing just through schools is, if you ask, "Most young people have never been bullied, will you ever be bullied?" They will say no—up until the point they experience it, and then they want help right now. One of the other challenges for us is actually using digital media so that we can become part of their world, that ReachOut appears in Facebook, it appears in the other parts of their digital world so that we can respond as well.

The Hon. PAUL GREEN: That is the point that Red Frogs was showing us. It had a small hospital for the kids. Many kids were immediately facing ideations of suicide because they had just finished the Higher School Certificate [HSC]. Many of them had crashed a long-term relationship or had a big blow-up with their friend whom they had come to schoolies with. Their world has turned upside down and they are suddenly suicidal. These people have not been wound up to that; they are suddenly there and they need that acute care.

Mr NICHOLAS: Yes and that is absolutely true.

The Hon. PAUL GREEN: If they had a number, such as the Red Frogs number, they could call somebody to get onsite and walk them through it.

Mr NICHOLAS: Absolutely true. We have always been focused since we were the first digital service in the world, that if an Australian young person types "I want to kill myself" into Google search—which is how they navigate everything—you want them to come to an Australian evidence-based service first. You certainly do not want them to go to a pro-suicide site or an American site. The challenge here we know is that the population has migrated online. When a young person is facing any question in life—it could be, "What am I having for dinner?" "Where am I going to the movies?" or "I want to kill myself"—their first response, their first inclination is to go online to look for that information. We need to make sure we are there or our colleagues in Headspace, beyondblue and others are there to provide them with safe pathways to further support.

We do that very well. I think there are certainly opportunities where we can scale up a lot more with the right marketing support, and certainly I think that the next opportunity is that we need to find smoother pathways to further support, so that if a young person chooses to go to face-to-face support, then we can help them get there from where they are. That gap is very significant. We know many young people do not want to call a telephone helpline or face-to-face support because they do not know what they will experience. If they start their journey online we can certainly help them find that further support.

The Hon. PAUL GREEN: Well done. That is great.

The Hon. GREG DONNELLY: On page 17 of your submission there are three tables. In particular I am looking at the top table. Can you explain the differentiation? A ranking running down and across the top has "No/low risk", "Recent thoughts" and "High risk". Where is this information extracted from? Is this a macro look at all your data, or a particular time period?

Dr BUHAGIAR: It is a subset. It is from a longitudinal cohort study that we did, which had about 2,000 users of the service. When we looked at the demographics it was fairly representative of the averages that

come to ReachOut. It is a fairly large sample compared with many other research studies; 2,000 users. As part of that we had a look at the suicidal ideation question. That is where we were speaking before about despite being a prevention, early intervention service, about 35 per cent of young people who access our services are experiencing suicidal ideation.

The Hon. GREG DONNELLY: With the categorisation of "No/low risk" or "Recent thoughts" or "High risk", who is making the call about which category someone falls into?

Dr BUHAGIAR: It is from the suicidal ideation questionnaire. It is a formal questionnaire that is used.

The Hon. GREG DONNELLY: It is dealt with elsewhere.

Dr BUHAGIAR: Yes. It is a standard battery of questions which are used for many types of studies of this nature.

The Hon. GREG DONNELLY: Looking at the three items of "Depression", "Anxiety" and "Stress", as a lay person I could mix them all up and wonder where someone fits into the scheme of things; for example, the identification of someone being depressed, as opposed to someone who might be feeling a bit stressed. How is that judgement exercised?

Dr BUHAGIAR: Again, through this research study. We also used what we call the DAS scale, which is the depression, anxiety and stress scale. It is a standard scale.

The Hon. GREG DONNELLY: That is the methodology that is used.

Dr BUHAGIAR: Yes. And we did that so that it is comparable with other studies of this nature, so that if we are using the same scales we can then have a look at other studies and see if there are any common ideas.

Mr NICHOLAS: That table actually refers to the content areas that the young people are choosing to navigate to. It is not necessarily just a label of their illness but what is the content that attracts them. What that shows is many young people are actually looking for help and information online around these very, very serious issues, often because they are experiencing them themselves or wondering whether they are experiencing them themselves. What we find is for everybody—whether it be young people or parents—content is actually a great pathway to further support. You are wondering what these words are, you are wondering whether they do relate to you. You come into ReachOut and you say, "Some of those things are sounding like me", or "Some of those things are sounding like my son or daughter." Then we are able through our content to map them to actions. As you said, on the site, on each piece of content it is not just information; there is a part there that says "Immediate relief". It is what can you do now.

One of the things we have heard consistently from young people is that everyone gives them very complex solutions, often involving talking to someone, but no-one tells them what they can do now. It is that sensation that I can take control now of something in my life is, in and of itself, very comforting. It then starts giving them further actions, which are often content and further apps and tools that they can use. Down the bottom, there are services and, where possible, it tries to map them to three-plus services.

The Hon. GREG DONNELLY: Map them to what?

Mr NICHOLAS: To services that might be appropriate for them. What we see from young people is that one of their frustrations with the service system is often that they are given only one option, and it is the option that they have most often rejected. I started my career with young men and they would say, "I feel really suicidal and I don't want to talk to someone." The response would be, "The best thing for you is to talk to someone." They would say, "I don't want to talk to someone." The response to that would be, "I've got a great idea. Can you talk to someone on the phone rather than face to face?"

One of the things that ReachOut has been able to do is to give young people options and then preferred options. That is an incredibly powerful way to help them to build up trust with some of those further services. What we see in the Australian community, thanks to a lot of destigmatisation, is that there is not so much a knowledge gap but a trust gap. Quite often young people know who can help them; they are just not sure that they trust that they are the right person to help them. It is certainly one of the great challenges for services. If there is a trust gap and you simply give them more information, that will not necessarily make them go. It is about how you can smooth out their journey, how can you give them a greater understanding of what they will experience, but also how you give them some limited choice knowing that every one of those choices is evidence-based and can help them on their journey. That is a critical part of how we can help suicidal—

The ACTING CHAIR: How do you achieve that?

Mr NICHOLAS: ReachOut NextStep is a tool to help young people predominantly to find further services. Depending on their distress, we give them a choice between further information they can read, actions they can take themselves, and services. Often we will recommend that accessing a service or seeing someone is the best thing they can do. However, we know that if they choose not to do that and take up one of those other actions that move them further along the journey, that makes sense. That is one of the great things we are able to do because ReachOut is scalable, anonymous and does not require talking to someone before you start navigating through the options.

The ACTING CHAIR: Trust is often based on the fact that you have built a reputation for delivering outcomes and all that sort of stuff. This has no ability to monitor that.

Mr NICHOLAS: Yes.

The ACTING CHAIR: I might say to my friends, "I have a really good service. I went to this place." How do you monitor whether you are breaching the trust gap that might exist? Is it simply word of mouth with one person saying to another person and that person saying to someone else that that is where I went for help?

Mr NICHOLAS: We can certainly pick that up through the evaluation. We can share with the Committee the evaluation of ReachOut NextStep. Part of providing people with that information does build up trust. They know more about the services because they have the options. The most important thing is that they have done it themselves. By navigating the system yourself, you are making choices and that, in and of itself, gives you a sense of autonomy and agency. On the other hand, being told that you have to go here or you have to speak to the school counsellor often removes that autonomy. We can certainly share some of those evaluations of how that trust is built up with the Committee.

Dr BUHAGIAR: The other issue is testimonials and stories and hearing about other young people's experience. The other thing we like to do is to support young people if they have an experience with a service or try to take the next step and it does not work for them. We try to ensure there is a range of other options. We have a breadth of content around facilitating that help-seeking process and helping the young person to be at the centre so they are making the right choices for themselves. We all know that they are then much more likely to access support and to stick with that support in the longer term.

Ms JODIE HARRISON: Page 7 of your submission refers to young people who have been identified as being at high risk of suicide through the Suicidal Ideation Questionnaire [SIQ]. Of them, 50.7 per cent did not seek help. Is that before they came to ReachOut or after?

Dr BUHAGIAR: My understanding is that that relates to professional help outside of ReachOut. They came to ReachOut, but they then said that they had not sought any kind of what we would call traditional professional support from a clinician of some sort.

Ms JODIE HARRISON: After not seeking help, they have come to—

Mr NICHOLAS: They have come to ReachOut, yes.

Dr BUHAGIAR: This is something we see a lot. Online digital services are often the first step for young people. When they do not have the confidence to take that first step in terms of picking up the phone or going to see their general practitioner or whatever, they will start going to online services. A lot of the tools that we use that Mr Nicholas has mentioned then help them to move through that journey and to take the next step available to them.

Ms JODIE HARRISON: When you do that local service mapping, how do you identify who is legitimate and who is not?

Mr NICHOLAS: It is certainly one of the things we have put to the New South Wales Government and the ministry. The opportunity now is about integrating digital services like ReachOut with that local infrastructure. At the moment we do not map at a local level simply because we do not have the resources to do it. We point people to national services that we know are there, such as the Kids Helpline, eheadspace and so on. From our point of view, that is satisfactory from a safety level. However, it is probably a big missed opportunity for connecting young people to the services that may be in their communities. We particularly hear this from young people and families in rural communities.

When we did the study in western New South Wales, they described the regional centres as donuts; that is, there are a lot of services around there, but there are big gaps to the next donut. If you happen to live between the two, it is a 300 kilometre or 400 kilometre drive. What we heard from parents when we were setting up the ReachOut parents' service that they are very happy, as any parent would be, to drive to town. However, they might not know it is a real issue when their child has come home and closed their door for the past three or four

days. Is that a reason to shut down the farm and to drive 300 kilometres? We see an opportunity for people who live a long way from some of those services to use online services to understand what are the service options. We can then help them to navigate and they may say, "Actually, what I am experiencing would be best met by a service." Then we find that people might then say, "Cool. This is not something that if I just avoid it will go away. This is something that a service in my regional centre will be able to deal with."

The best opportunity to integrate into State infrastructure would be to take this large national audience that we have—we will continue to reach tens of thousands of young people and their parents every month—and continue to provide very high quality self-help and to give them the tools to manage things themselves. The missed opportunity is about more efficiently helping them to navigate to the right service for them in the community that is closest to them. At the same time, once a young person is involved in the community, our challenge is that too few of those services are integrating digital into their recovery plan. Again, we see it as a missed opportunity that if a young person is getting high-quality clinical help that the clinician can direct that young person to our peer support community and we can keep them safe and engaged when that clinician is not available. If things do escalate, we can always refer that young person back into clinical care, but use the capabilities that are best met by the environment.

Mr MICHAEL JOHNSEN: You mentioned being able to access services as close to home as possible.

Mr NICHOLAS: Yes.

Mr MICHAEL JOHNSEN: I am a regional member from the Upper Hunter. I have anecdotal evidence, predominantly from headspace. Headspace in Maitland tells me that many young people from the Upper Hunter go there and do not necessarily access local services that may be available. That comes back to the issue of trust, stigma and things like that. Do you have any evidence, statistical information or anything else that might indicate that they do not access available services in the nearest town, for example, 200 kilometres away? Are they prepared to travel 400 kilometres so that there is a level of anonymity?

Mr NICHOLAS: We have just finished a large study of young people in rural Australia, not just rural New South Wales, about their attitudes to help-seeking and their preferences for help-seeking and I am happy to share that with the Committee. At an anecdotal level that is true. What you see is a knowledge gap and that knowledge gap also involves a trust gap. People may have a view on a particular local service but as was shared that might be informed by what three other people said in their community and it gains a reputation. What we see most often is that mental health is not on most young people's radar most of the time. They are having fun. When that crisis hits they are trying to work out for the first time in high distress what to do and where to go. They do not necessarily, in fact most of the time, remember the presentation they got six months ago or the phone number they got two years ago.

They want that information right now and are trying to solve that on the fly. What we would like to do is more deeply integrate ReachOut and ReachOut NextStep into that local infrastructure, better explain to a young person as they are making that search what is the difference between a headspace and a local service. It may be significant or it may be insignificant for that young person. If we are better mapped there are opportunities to track user flow: where do people go? Do you see service increases? We can better understand whether we need to challenge some of that local service trust issues. Most of the time young people say, "I don't know where to go and every service kind of sounds the same so I just pick one."

Mr MICHAEL JOHNSEN: And they do.

Mr NICHOLAS: And they do. Quite often it is the parents. This is the critical role that parents play. As is appropriate the parents are making that choice. We started ReachOut Parents because we found that there was a wealth of information and support there for parents of kids under the age of five, both commercial and non-commercial. We know that there is a significant escalation in difficulties when the kids hit their teenage years, but there was a gap in online services. We hear time and again from parents that it is only at 11.00 p.m. when you are in bed and the kids are finally asleep that you get a chance to talk to your partner and go, "Have you noticed that something is going on for the last three weeks?" And they go, "Yes, actually". And then they start their navigation online. We can help them navigate. We see there are some big opportunities about using digital information services to help parents both talk to their kids and navigate to services, whether it be eheadspace or other services in their community.

Dr BUHAGIAR: One of the things that would be a dream for us is that as we are mapping in those services and working with services to integrate them into the tool list is to provide information such as waiting times so that families then have an option of first or nearest. Do they want to get the appointment that is sooner

or would they prefer to travel. It gives them more control over that decision and they are much more likely to take the next step.

The ACTING CHAIR: I admire your passion, which is evident from the way you talk about the service you offer. It is refreshing. If we send you questions after you leave, are you happy to send responses in writing?

Mr NICHOLAS: We would be absolutely delighted.

(The witnesses withdrew)

CHRIS MILLER, Principal Consultant, 3rd Degree Consulting, sworn and examined

MARK DONKERSLEY, Managing Director, eSafe Global Limited, sworn and examined

The ACTING CHAIR: You will have received an information pack before you came today. Do you have any questions arising from those standing orders relating to the giving of evidence here today?

Mr MILLER: No.

Mr DONKERSLEY: No.

The ACTING CHAIR: Mr Miller, you sent the Committee an email telling us how much we do not know about your organisation.

Mr DONKERSLEY: I half apologise for that.

The ACTING CHAIR: Perhaps a lot of the questions we were going to ask you have encapsulated in questions for us. In your opening statement you might tell us about yourself and address some of the issues you have raised in the email you sent to the secretariat.

Mr DONKERSLEY: Thank you for giving eSafe the opportunity to submit evidence to this Committee. We are here because of our feet on the ground in Australia, which is Mr Miller. He is our Australian with knowledge of the local issues. I am here today to try and share with you some of the experiences that we have from the United Kingdom [UK] from a safeguarding perspective which dovetails very neatly into this particular inquiry. There has been a lot of talk today about the digital environment and that is exactly the environment we use to identify behaviour markers. From a safeguarding perspective in England and Wales schools and colleges are tasked, there is legislation on statute books, with taking safeguarding incredibly seriously. It can be a career limiting issue to pay lip service to it.

The wellbeing of individuals is incredibly important, as I am sure it is here. They have gone a step further in England and Wales by actually mandating that thou shalt do it otherwise face the wrath of the law. We are a company that focusses on the wellbeing of students and staff, particularly young people, young adults and children in the primary, secondary and college education system. The stage that we are involved in is very much identification. There is not a great deal that can be done until you know a risk exists. Again, hearing the evidence today in earlier submissions clearly Australia has a lot of what I would call disparate systems, processes and organisations which have the capability to pick up on risk when it is identified, but probably where the holes appear to be in comparison to the UK is in the initial identification that that risk exists.

Basically, we are using the school digital environment and the school devices which are made available to young people, which might not necessarily be used in school but may be used at home. They may be vulnerable young students that are in care. We are basically effectively watching for markers of a raft of different types of behaviour. That can be extreme child abuse, grooming, paedophile type activity, bullying of a cyber nature, self-harm risk, anxiety, depression etcetera. Predominantly the behaviour that outweighs all other behaviours in England and Wales is mental health, to the tune of 40 odd per cent of all incidents that we escalate are mental health related.

That is the same with the much smaller section of schools that we monitor in Western Australia. Again mental health is at the top of the tree, the league table, when it comes to the category of behaviours we identify there. There are some slight differences. Our league table is mental health followed by threats of violence, followed by drugs—stealing or buying in school or outside of school but using school equipment to perform that function. In Western Australia it is mental health, followed by pornography, followed by drugs. The relative positions of those different categories are very similar in percentages.

We are all about the early warning identification to enable those charged with safeguarding responsibilities, pastoral care in the school or other agency, to intervene, and either refer individuals, engage other agencies or try and address the situation at hand.

Theresa May, our Prime Minister, has focused heavily on mental health. Approximately 50 per cent of all the established mental health conditions in England and Wales are established by the age of 14, and 75 per cent of them by the age of 24. So clearly these issues are occurring, building and developing during school years. One in 10 of all children between the ages of 5 and 15 have a clinical mental health issue. That is a significant number of people, and it is costing the country something like £UK100 billion a year to address that, and that figure is rising. Again, the emphasis is that if you can get in early you can identify the risk as it is

starting and you have a much better chance of diverting the person away from what could be the ultimate end game—suicide.

In addition to the early warning intervention, we are providing, effectively, a window on genuine activity that is taking place involving young people in the school environment. We are not using analysis and statistics based on surveys. It is based on what we physically see. As their behaviour marker occurs we have a team of behaviour analysts who review that marker and determine whether or not it needs escalating. So we can see how much pornography is being viewed today, yesterday, last month and last year in a school, in a region and in a country.

We are not viewing everything. Clearly we are just one part in the jigsaw. We are not replacing the eyes and ears of teachers. We are not replacing the sort of system that Reach Out talked about in the previous session. We complement those. But we do have the statistics. I heard earlier today that data is a key area for you. You are behind the curve and chasing the statistics all the time. We have the statistics at our fingertips through the monitoring, so we are able to give those charged with policy-making decisions in the United Kingdom, and those planning the interventions, not just an understanding of what is going on today but the trends and the forecast. That way you can tailor your program of interventions to suit the types of behaviour that are prevalent at that moment in time.

We feel that here in Australia we have a means of early warning and evidence based data across metropolitan, regional and rural areas of the types of behaviour that you are concerned about. Nearly all of the behaviours that we detect can lead to mental health problems—whether it is someone who is being groomed, someone who is being bullied, someone being abused in some way, or someone who is spending a lot of time looking at pornography who, at the age of 10, should not be doing that on a daily base. Looking at pornography at that age is not illegal but clearly they have been subject to material that has the ability to skew their outlook on life.

The ACTING CHAIR: I will give you the opportunity to take a breath. As you were talking, the thing that overwhelmed me a bit was the privacy issue. Do people know you are doing this, or monitoring this in the background?

Mr DONKERSLEY: Yes.

The ACTING CHAIR: Do parents know? Do the kids know that you are watching?

Mr DONKERSLEY: Indeed. The parents and the students in England and Wales effectively sign an acceptable-use policy—a code of conduct around behaviour—when a digital environmental has been made available to them or a computer has been given to them.

The ACTING CHAIR: Under the heading of the code of conduct, that gives you access to monitor compliance with the code of conduct.

Mr DONKERSLEY: Yes, indeed. That is under UK and EU current data legislation.

The ACTING CHAIR: That is an arrangement that you have with the education department?

Mr DONKERSLEY: And the individual schools.

The ACTING CHAIR: Is the arrangement with the individual school or departmentally?

Mr DONKERSLEY: The Department for Education in England and Wales says that monitoring should be performed. We, at an individual school or college level, agree with a particular school the level of monitoring that is appropriate and required for that particular establishment. The service is confidential to the individual school, and we monitor based on what they want us to monitor. We are not recording things. We just look at the devices which the school has provided or has made available to the young person to use.

The ACTING CHAIR: Mr Miller, does that happen in Western Australia?

Mr MILLER: Yes, it does. They key thing about it is that it does not deliberately capture any personally identifiable information. We have the student log-in details—which might be C8906906.

The ACTING CHAIR: That is personally identifiable.

Mr MILLER: If somebody intercepted the data they would not be able to identify the individual. It cannot be taken back to the individual student until the school gets the report.

The ACTING CHAIR: Just stopping there, you could give a report to the school that a student identification number accessed this pornography site on this day.

Mr MILLER: Yes.

The ACTING CHAIR: You are able to do that?

Mr MILLER: Yes.

Ms JODIE HARRISON: That is identifiable.

The ACTING CHAIR: It is pretty identifiable.

Mr MILLER: Only to the school; not to anybody else.

The ACTING CHAIR: That is part of the arrangement that you have with the department there.

Mr MILLER: The school can decide that they do not want to know that information. They can choose not to have that, and then we do not report back on that. There is a list of elements that we can identify and report on, and the school can decide which one of those they would like us to monitor.

The Hon. GREG DONNELLY: Do the kids not wise-up and use their own devices, like their smart phones to subvert the whole thing?

Mr MILLER: Yes, they will. But this is not a sanctioning tool. It is not to try and catch kids doing something wrong When they are trying to do something wrong they will find ways around things. This is all about early identification of mental health issues. Mark has statistics which show that the mental health aspects of the behaviour do not change when the kids know they are being monitored or when they do not know that they are being monitored.

The ACTING CHAIR: I now have that clear.

The Hon. PAUL GREEN: It is pretty diverse, is it not? The service monitors for markers that indicate safeguarding of risk and illegal behaviour including illegal imagery, illegal activity, grooming, child abuse, self harm and suicide risk, pornography, bullying and harassment, radicalisation, trafficking, FGM, substance abuse, threats of violence, gang crime, et cetera. The service monitors imagery—static and moving—and words and phrases against a dynamically maintained library of threat markers. So the school can ask for any of that?

Mr MILLER: Indeed.

Mr DONKERSLEY: In the United Kingdom, all of those items that you have just read through are on a list of safeguards and risks and every school leader must have some process in place to identify them.

The Hon. PAUL GREEN: It is pretty broad.

Mr DONKERSLEY: Absolutely.

Mr MILLER: We have had some schools which have said that they only want to monitor the wellbeing aspects—the mental health issues. This will work 24/7. Some schools have said they only want to monitor between 8.00 and 5.00 p.m. Other schools are boarding schools and the boarders get monitored 24/7 and day students are monitored between 8.00 a.m. and 5.00 p.m. So we can configure it in whatever way the school would like.

The ACTING CHAIR: How large is the penetration into schools in Western Australia?

Mr DONKERSLEY: It is about 9,000 students—very small compared to the three-quarters of a million-plus that we have in the United Kingdom.

The ACTING CHAIR: What has been the result in Western Australia? Have you done some analysis of what you are detecting?

Mr DONKERSLEY: Indeed. We are happy to share the granular detail of those. The highlights are what I mentioned earlier. Mental health is, as in the UK, the most significant. But whereas we are threatening each other with violence in England and Wales, in Western Australia they seem to be viewing pornography as the number two. Drugs is the third largest behaviour activity in both countries.

The ACTING CHAIR: That is the information that you are able to share with the school. What is the response of the educators? On an individual basis what does the school do with that information?

Mr MILLER: Obviously it depends on the school and the issue at hand. It allows the school to identify these incidents very early on in the process. At the moment schools are largely identifying these issues when they become 6 o'clock news items. We like to find them back here, where the intervention might be a group intervention rather than a one on one intervention with a student. You might be able to get a class of year 9 students and discuss sexting and the impacts that that might have. The other aspect of eSafe is that at the

moment we have all these training programs such as this cyber awareness course and we had Cyber Safety Day last week, and we have all these programs. At the moment, it is very difficult to validate the effectiveness of those training programs. What eSafe can do, we can look at the behaviour of those students before those training programs and again one month later, two or three months later and determine the effectiveness of those training programs on that cohort of students.

The ACTING CHAIR: You say it alerts the school to the necessity for perhaps talking about some issues that they were not necessarily—

Mr MILLER: The specific incidents that impact that school, because all schools will have different—schools that are located very close together will often times have very different issues. Having a cut-and-paste training session from school to school may not be the best use of the kids' time and the training. We can identify specific issues to a specific school or region.

The ACTING CHAIR: What does the eSafety Commissioner have to say about your program?

Mr MILLER: We have met with Julie once and we have met with her team on a number of occasions. Basically they said they have seen nothing like this before.

The ACTING CHAIR: Nor have I.

Mr MILLER: We have also had more than a dozen meetings with the public education in Queensland. The response we got eventually was: We have no problem with this going into our school system.

Mr DONKERSLEY: One of the points that was raised earlier about the communication between young people when they are suffering from some sort of mental health issue, the evidence that we have is that the vast proportion of the behaviour markers for the recipients of things like cyber bullying—so the people who are becoming anxious and depressed because they have been bullied—they are not communicating that to someone else. They are not using chats or social media for that. We can see the difference between what we call "truly online"—a chat, social media on the internet—verses offline, "I am just writing a note to self. I am unburdening my anxiety" into something like Microsoft Word.

Even to the extent of someone writing some course work, a history essay, they will get to a certain point and then they will write a paragraph how things are not going right at home—they do not want to go home, they feel this, that and the other, delete it and carry on with the course work. That is a marker that we have captured. It is early stages. It is not, "I am going to jump off the Sydney Harbour Bridge at 4 o'clock". Although that sort of thing happens on occasions, it is much possibly two years before then that things are not right. We are actually opening a window into that offline environment where in the United Kingdom [UK] we see this prevalence of people writing notes to themselves even though know they are being monitored.

The ACTING CHAIR: In the UK experience, anecdotally or factually, what has been the success rate of using this tool for suicide prevention?

Mr DONKERSLEY: There is anecdotal evidence from lots of school leaders and parents about having identified a serious genuine suicide risk early enough to have intervened and actually prevented it. It has also corroborated existing evidence that a school or parents might have about the anxiety and serious nature of a suicide risk with an individual. On occasion, sadly, it has identified something that neither the school nor parent was aware of immediately prior to a suicide attempt being made.

The ACTING CHAIR: That is only anecdotal. You do not have any mechanism for giving actual reports?

Mr DONKERSLEY: We do in respect of the feedback loops we have with the schools. The detail of it is confidential with the school, the parent and the individual concerned but the anonymous information is made available and that sort of granular detail I am happy to share with the Committee separately.

Documents tabled.

The Hon. GREG DONNELLY: Surely in respect of some of these items listed in that paragraph on page 11 the identification of the manifestation of some of these would activate certain obligations under statute law to inform the police force, for example. You say the school is informed. I understand that, but are there not obligations that if there is an awareness of at least some of these matters that either the police force or the relevant security agencies are informed that something has been identified?

Mr DONKERSLEY: The way the protocol works with most schools is that an illegal incident is reported and we request the equivalent of a crime number from the school which will have been obtained from the police within 48 hours. If within 48 hours we have not been given the crime number we will chase the

school again. If we do not get it immediately, we will report that incident to the police. Invariably, if it is something like child abuse imagery then clearly we have a copy of that image. We might be the only people who have that image and it is important that the police determine the retention and everything else that happens to that image moving forward.

The ACTING CHAIR: Or a drug transaction?

Mr DONKERSLEY: Absolutely, the same with that, and radicalisation as well. You know, there is a lot less of that happening. Female genital mutilation in the UK is illegal. I imagine it is probably illegal here as well. That sort of thing is far more suitable. People do not write, "I am going away next week to be circumcised." But we pick up Muslim teenage girls who are concerned about the fact that a holiday has been lined up for them, they are expected to go out of the country. There are various euphemisms for that sort of behaviour, as I am sure there are here, and that is the trigger; that is the identifying mark. Again, we are trying to capture things early. Going back to your point about the granular detail, because of the way we look for the markers we tend to pick up early warnings as opposed to someone about to jump off the Sydney Harbour Bridge. It is very difficult to turn around and say, "Well, as a consequence of those incidents 20 suicides were prevented." We are talking about two years perhaps before those suicides would have occurred and the individuals have been steered away from that particular path and guided and supported in an appropriate manner.

Mr MILLER: With the table I have presented, there was feedback from the school. We ran a five-week trial at a particular school. One individual was identified and is now receiving outside counselling for a depressive illness that nobody in the school was aware existed. It is impossible to say that that may have culminated in a suicide or a suicide attempt, but counselling is being given to an individual now.

The ACTING CHAIR: But there were a number of incidents where there was a suggestion from the key strokes that were being monitored of potential drug activity.

Mr MILLER: Five kids were expelled from a school because they were transacting drugs on the school premises.

The ACTING CHAIR: That all came about as a result of your monitoring?

Mr MILLER: That is right.

The ACTING CHAIR: So Mr Donnelly's point about using external devices for those purposes, clearly they did not?

Mr MILLER: They have a short attention span. We normally see a drop off in activity. The school will have a benchmark of incidents that they normally have to deal with. We see a drop off initially and then a huge spike once they forget they are being monitored. Once the intervention starts to take place it drops off sharply. It is a behaviour modification tool.

The Hon. PAUL GREEN: Do you want to table that document?

The ACTING CHAIR: I think privacy is attached to it.

Mr MILLER: Is it helpful? It has all been cleared; it is fine.

The ACTING CHAIR: There are no identifying features. We do not know what school it is or anything like that?

Mr MILLER: No.

The ACTING CHAIR: We do not have to publish it but it is certainly information.

The Hon. GREG DONNELLY: Has Western Australia signed up for the whole box and dice—I refer to page 11—or has it gone for a qualified set of the market?

Mr MILLER: The schools that are using it in Western Australia at the moment have signed up for the whole range of services, of monitoring.

The Hon. PAUL GREEN: Are any other States looking at doing it or private schools?

Mr MILLER: Yes. We have had several meetings in the past few weeks. We have met with the National Mental Health Commission and it has been really active in trying to introduce this into other organisations. We do have a number of meetings coming up with education departments in other States. I will be in Western Australia in the next week or so and then down to Canberra as well. Queensland has been the most active so far.

The Hon. PAUL GREEN: I thought you said that you were active in Western Australia.

Mr MILLER: We are, yes. Dr Jim Watterston is the Secretary of Education in Queensland. We started with Dr Jim and then we have met with several people beneath him in the organisation.

Ms JODIE HARRISON: You are in Western Australia?

Mr MILLER: Yes.

Ms JODIE HARRISON: You are going into Queensland ?

Mr MILLER: Yes.

Ms JODIE HARRISON: Is there anything happening in New South Wales?

Mr DONKERSLEY: There is interest in a couple of public independent schools—I am sorry, I am using United Kingdom terminology. Independent schools, private schools, perhaps. That is on the basis of conducting trials, and that should start in two or three months time.

Mr MILLER: From the conversations I have had with principals and deputy principals of public high schools they have been very receptive—far more so than the private schools.

Ms JODIE HARRISON: Are they interested in the whole lot or just mental health?

Mr MILLER: I have not had that discussion with them yet. One of the schools I have spoken with—and I think I mentioned it in the submission—had a cluster of suicides over a short period. I have spoken with the deputy principal since and the suicides are not so much with the children; it is with the parents. A 45-year-old man, the father, is the most likely suicide candidate. They are very interested in it particularly for that aspect.

Mr DONKERSLEY: I met with a school early last week and it was concerned about what it did not know. They have the baseline. Their fear was there was more happening than they could see. That school was very motivated towards safeguarding and the wellbeing of students, as you might imagine. They see the trial as a way of corroborating that there are things going on that they are unaware of and the parents are unaware of, that really require support and intervention now.

Mr MILLER: I think one of the most important aspects, we have had a number of organisations speak, and the purpose of the gatekeeper strategy that we have at the moment is for individuals to pick up little pieces of information that a child may present with. The difficulty is there is no aggregation of that information. What eSafe allows is the communication that the kids have, it aggregates that. One of the examples is a girl who wrote something very subtle. Somebody just searched for how to commit suicide on line. On its own that would not have been an extreme risk straightaway, but the review team was able to go back and look at other low-risk incidents for that particular individual, aggregate that information and say, "We are going to escalate that now and it becomes high risk." It is a United Kingdom incident and the girl is now receiving counselling.

Ms JODIE HARRISON: Some schools in New South Wales require you to bring your own device. Basically all students in New South Wales have an education email address but I know both my children have an iCloud email and a Gmail account.

Mr MICHAEL JOHNSEN: Those are the ones you know about.

Ms JODIE HARRISON: Those are the ones I know about. Would they be captured under this system? Would it just be whatever is captured under the education email address that is issued, or do you opt in for other systems?

Mr MILLER: No. Not everything will be captured. We only capture if there is a policy violation. Most of the kids will never have anything captured until they write something, do something or view something that breaches a policy that we have. Then it gets captured. Until then we sit there benignly doing nothing.

Ms JODIE HARRISON: If a student is using a Google account which is not on an education department issued device and is not linked in with the education system, would that data get picked up by eSafe?

Mr DONKERSLEY: If you are outside the school's Google environment—you might be familiar with the concept that Google has with G Suite which they give to a school free of charge? Basically, it aggregates all of the Google activity through the school account. Unless you put your personal credentials into your device you will automatically get routed through it, even if you are at home on a personal device. What we do is we actually geolocate the school. So if the device, which has been routed through the Google account is not physically within 10 or 50 metres of the school, or whatever, then it does not get monitored.

If you are using a bring-your-own device, assuming that the parents have given permission for that device to be monitored—the school has probably said "If the device is coming into school, we want it to be monitored" so it is not a case of yes or no' it has to be yes—that device will be monitored when it is physically connected to the school environment, whether it is the network or the Google cloud. But if you take that away and you do a 4G connection to whatever your communication company is and you decide to go off and look at some pornography or email, or whatever, we do not see that because we are outside the school environment.

Ms JODIE HARRISON: Anything that happens in that case relating to mental health probably would not be picked up?

Mr DONKERSLEY: To a degree. Obviously a significant amount happens on mobile phones but a lot of material comes from mobile phones back into the school environment. You will get people who are being bullied, perhaps on Facebook. They have read the bullying message on Facebook on their mobile phone, but because they know the school environment is monitored they will open Facebook from a school device because they then know that the school is actually going to see the inbound bullying statement that has come through. We see that a lot.

Going back to pornography in Western Australia, when I was at school in the 1970s you looked at *Playboy* or a piece of paper ripped out of it in the corner of the playground and someone would say, "Go and see Fred because he has got some interesting pictures." Now it is the case of someone coming in with a video or something pulled down on their phone from the night before, but rather than looking on a 4 x 4 screen that material gets planted on the school document drive. The inscription that goes out to the student says, "Next time you are unobserved, go and look at past exam papers for 2017 and you will find some interesting pictures there. So the material gets brought back in.

The really good thing about monitoring is that a lot of the schools in the United Kingdom without monitoring locked down social media. They will say, "You are not going to use Facebook, Twitter, Instagram or whatever." With monitoring they open that up, allow that to be done on school devices and rely on the monitoring to find out if someone is misusing that particular privilege. The beauty there is it brings the students back into using the school equipment. Again that is where the markers actually appear.

Mr MILLER: The big benefit is having the review team in the back ground who can identify really subtle markers and put context around that violation. They can determine why that content triggered violation and was captured. That comes back to the school and the school can then make a decision on what is done with that.

Ms JODIE HARRISON: Where is that review team at the moment? Is it in the United Kingdom?

Mr MILLER: It is in the United Kingdom, yes. They are mental health specialists.

The ACTING CHAIR: This has been an enlightening session. I am appreciative of you coming today and giving evidence as I was not aware that this information was available. As you rightly say in your note, we would not have known how to ask these questions if you had not told us how it operates.

Mr MILLER: It is not a new service. It has been around for about 10 years in the United Kingdom where 750,000 students and staff are being monitored. The work is fantastic.

The ACTING CHAIR: If Committee members have any further questions and we send them to you I take it you are happy to send us a written response?

Mr MILLER: Absolutely.

Mr DONKERSLEY: Indeed.

(The witnesses withdrew)

(The Committee adjourned at 17:01)