REPORT ON PROCEEDINGS BEFORE

COMMITTEE ON CHILDREN AND YOUNG PEOPLE

PREVENTION OF YOUTH SUICIDE IN NEW SOUTH WALES

At Jubilee Room, Parliament House, Sydney on Monday, 5 March 2018

The Committee met at 9:30 am

PRESENT

Mr Damien Tudehope (Chair)

The Hon. Greg Donnelly
The Hon. Wes Fang
The Hon. Paul Green
Ms Jodie Harrison

The ACTING CHAIR: Good morning. I declare open the third hearing of the Committee on Children and Young People's inquiry into the Prevention of Youth Suicide in New South Wales. Thank you for appearing today. The Committee held hearings in regional New South Wales last year and a fortnight ago it held another hearing in Sydney. Today we will be hearing from headspace, the Black Dog Institute, representatives of the NSW Ministry of Health, the Department of Family and Community Services, the Department of Education, the AIDS Council of New South Wales, Twenty10, yourtown, and the Lifeline Research Foundation.

As the Committee has mentioned previously, this is an important and sensitive subject. I know that this issue may affect people in the room because we will hear anecdotes about circumstances with which I am sure your organisations are familiar. They are sometimes distressing and I encourage people to seek help if they need to by contacting Lifeline or Kids Helpline. I now welcome representatives of yourtown and the Lifeline Research Foundation. Thank you for appearing and for the submissions you have made to the Committee.

TRACY JOY ADAMS, Chief Executive Officer, yourtown (Kids Helpline), sworn and examined

SAMANTHA JANE BATCHELOR, Senior Researcher, yourtown (Kids Helpline), affirmed and examined

ALAN ROGER WOODWARD, Executive Director, Lifeline Research Foundation, sworn and examined

The ACTING CHAIR: Would you like to make an opening statement and elaborate on your submission?

Mr WOODWARD: Before expanding on my submission I acknowledge the traditional owners of the land on which we are meeting and pay my respects to elders past and present. I also acknowledge those who have lived experience of suicide and the loss and grief it causes. Lifeline is a charity with a vision of an Australia free of suicide. We believe in a compassionate and understanding approach to the experience of suicide and the loss involved. The subject of youth suicide is of considerable concern in our community. That is in part because we have recently seen the rate of suicide reaching a 10-year high in this country, but also because of an understanding that more than one in three deaths of Australians under the age of 24 is a suicide. It is in fact the leading cause of death for Australians under the age of 44 years. Suicide also accounts for the highest number of years of life lost as a measurement of impact of any health issue in this country. Suicide is a critical health and social issue.

We remain perplexed when suicide deaths occur in our younger population. There are some key factors relating to youth suicide that are worth noting to establish what might be effective responses. First, we must acknowledge that youth suicide has some different features from suicidal behaviour and deaths that occur in older age groups. For instance, younger people and young adults are going through critical development phases in their life; they are still maturing. That sometimes results in difficulties with problem solving or in dealing with negative life events, some of which may be shaped by their experiences in childhood.

Secondly, it is now widely accepted that where mental ill-health may occur in a person's life, in 75 per cent of cases it will be observable by the time the person reaches the age of 24. Contrary to the experience of physical ill-health, where manifestations perhaps occur later in life, mental ill-health is more likely to occur during the young years. The third issue to acknowledge is that there is a social dynamic that can occur in relation to the behaviours of young people in their suicidality. I understand that this has been noted in several submissions to the Committee, but the role of peer group pressures, of media and social commentary, and of a social dynamic is one of the factors to give particular attention to in addressing youth suicide.

Lifeline is a national charity that has operated in this country for 54 years. From its very origins, it sought to prevent the loss of life by suicide but also to extend a compassionate, non-judgemental and empathetic offer of help to those experiencing profound distress and difficulty in their lives, and to do that through innovative ways—in 1963 through the use of the telephone and in 2017-18 through the telephone, certainly, but also through online chat, and we are in the process of developing a text-based service. Also from our origins we have established a community presence through our Lifeline centres that engage with people to volunteer and support our cause and also to be involved in community services and programs. In New South Wales there are 12 Lifeline centres operating, providing a range of community services that complement the Lifeline crisis support services.

Lifeline sees that there is a real role for the offer of immediate help for those in crisis as part of any national or State-based suicide prevention strategy. We believe that the offer of help to a person in crisis or severe distress will, at times, result in saving a life and can certainly act to interrupt the suicidal cycle and provide the offer of support for a person who may feel profoundly alone or distressed in their suffering. As a result, the crisis support services also provide an avenue to support help-seeking and to encourage linkages with other services and supports that may have a longer term benefit.

We also believe that there is a need for preventative or upstream measures in suicide prevention that include the raising of awareness with individuals, equipping people with ways in which they might earlier seek help and address the challenges in life. This is a particularly important aspect of building greater suicide prevention for young people. Similarly, we believe that there are social factors and economic factors that might influence a person's understanding of the world around them and sometimes lead to distress.

Lifeline commissioned research work last year from Dr Allison Milner at the University of Melbourne analysing the data on suicide deaths in Australia over a 10-year period against factors to do with employment, family circumstance and socio-economic status, and found wide variations in the experience of those factors as reflected in deaths region by region or primary health network by primary health network across this country. These statistical results further underpinned that there is a community context in which suicidal behaviour can

occur. Lifeline believes that while it is absolutely essential to extend the offer of help and support to individuals in an immediate and effective way, so too is it important that there are community-based actions for suicide prevention that address some of the ongoing issues that might affect a person.

In making this submission to this Committee, Lifeline joined with two colleague organisations: Orygen, the youth mental health research centre at the University of Melbourne; and batyr, which is a similar charity in nature, providing outreach programs to schools and college or university aged people. We deliberately chose to provide the Committee with a joint submission because our three organisations are working closely together and we wanted to demonstrate to you that this sort of collaboration can occur. I hasten to add this morning that our colleagues from yourtown operating Kids Helpline and a range of very high quality programs for young people are also colleagues that we work with readily and have so done for many years. We wanted to reinforce to the Committee that amongst those of us working in the field there is a great desire to work together and also to work with governments and private business and communities in the quest to reduce the deaths by suicide and again in relation to Lifeline's vision of an Australia free of suicide.

The ACTING CHAIR: Ms Batchelor, do you wish to make an opening statement?

Ms BATCHELOR: Yes, thank you. First, thank you for the invitation to be here today. yourtown provides a range of support services to vulnerable and marginalised children and young people across Australia, and we come across young people thinking about suicide in all those services. But the key service relevant to this is Kids Helpline, the national 24/7 telephone and online counselling service for five- to 25-year-olds seeking support on a wide range of issues, which increasingly is including suicide. Through delivery of Kids Helpline and through our research we hear from young people thinking about, planning and attempting suicide firsthand. In 2017 more than 113,000 attempts to contact Kids Helpline were made by young people in New South Wales, but our counsellors were only able to respond to 58 per cent of these attempted contacts. Of those we responded to, an average of just over 50 each week were from young people in New South Wales seeking counselling in relation to suicide.

Kids Helpline [KHL] is approximately 80 per cent self-funded by yourtown, and the New South Wales Government does not provide any funding support to KHL. yourtown strongly believes that young people are the experts in their own lives and it is essential that their views are used to inform the design and delivery of sustainable and effective services to support them. Hence, in 2016 we surveyed 472 young people who told us about their experience of seeking and receiving help when feeling suicidal and shared the messages they would like to give to those around them, including service providers and policymakers. Today I want to take this opportunity to expand on our written submission to this inquiry by sharing some of what we learned from young people.

Evidence of what works in terms of programs, services and policies to prevent suicide by young people is limited. Suicidality is far too complex for any single solution. Moreover, every young person who thinks about, plans or attempts suicide has followed a different path to arrive at that place. When we listen to children and young people, we do, however, see common factors. They feel that they do not really belong anywhere, that no-one really values them or cares about them, that they are unimportant. This may be accompanied by a sense of failure or self-hatred, leading to a belief that others would be better off without them. When a young person loses any hope that this will ever change, the emotional pain can become unbearable and suicide seems like the only solution.

Encouragingly, young people also told us that when they did receive help, it usually made a difference. However, when they wrote about the benefits of things like professional counselling, they did not write about therapy or treatment. In fact, many find a clinical approach alienating and off-putting. Young people wrote about the relationship they had with a professional. They told stories of counsellors making an extra effort to make them feel important, to show that they cared, of counsellors who listened without judging and never gave up on them. What was also clear was that the value of genuine caring and compassion is not limited to a therapeutic relationship. Whether they are talking to a GP, a teacher at school, a parent, a friend or a nurse in an emergency department, young people are seeking evidence that they are valued and important.

So the answer seems quite simple: Provide that support. Show these young people that they are wrong—they are valued and cared for—that they matter, that they have an important place in their family, their school, their friendship group, and that things will get better. Unfortunately, this is not as easy as it sounds. Most young people do not seek help because they are scared that seeking help will actually make things worse—that they will be called an attention seeker, that their feelings will be trivialised or ignored, that there is nothing anyone can do anyway. They also do not want to worry the people they love, and they put others' needs above their own.

At the heart of this issue is stigma. "Stigma" can be a bit of a nebulous concept, so I would like to make it more concrete. Stigma means your best friend saying, "Just grow up and deal with your problems," when you tell her you are thinking about ending your own life. It means health professionals calling you "a waste of a hospital bed and a burden on the health system", when you have just tried to kill yourself. It means being given a lecture about budgeting when you are a homeless teenager collecting a food package. These are all real experiences of our survey respondents. Stigma means that just at the time they most need compassionate support, young people are made to feel more ashamed, more isolated, more distressed and more scared, and the next time they feel suicidal they stay silent, which heightens their risk—that is, poor responses do harm.

What young people also highlighted to us is the importance of family. When young people talk to a Kids Helpline counsellor about suicide, the most common co-occurring concern is family relationships. Poor family relationships are a risk factor for suicide, and strong family relationships are a protective factor. But many young people tell us that their parents do not know how to respond, even when they explicitly ask them for help. Moreover, in addition to being a crucial source of support, in and of themselves, parents are the gateway to professional support for children. So we need to do a few things.

Firstly, we need to build young people's confidence to share their feelings and ask for help, but we simultaneously need community-wide programs to increase understanding of suicidality and mental ill health and ensure that when they do seek help young people receive a helpful response, regardless of who they approach. More than that, we need to teach adults to be proactive, take the support to the young person and not wait for them to come looking. Then we need to provide child friendly, professional mental health treatment that is easily accessible, even for young people who lack the support of parents. It must be provided by youth specialists with the patience and skills to connect with a child in distress, which is often not easy. Finally, that specialist support needs to be provided for as long as it takes, not for as long as the funding allows. In other words, we need to build a system of care around the needs and preferences of the young person, rather than the adults managing the system. Thank you.

The ACTING CHAIR: Thank you very much. Did you say that none of those services currently exists?

Ms BATCHELOR: The services that provide compassionate caring?

The ACTING CHAIR: Yes.

Ms BATCHELOR: They certainly do exist. There are definitely big gaps. We see a lot of younger people, especially under 12-year-olds. Kids who are not yet eligible for headspace really lack any kind of non-clinical early intervention. There are some government-funded services. In fact, we run the Australian Government-funded early intervention Family Mental Health Support Services, but they are not available everywhere. We have waiting lists. There is not enough of them for every child. Beyond that you get differences between services. We need to make them more consistent. Even where there is a service, we need to know that whenever you go there will be services available and you will get the right support.

The ACTING CHAIR: You would probably be aware that lots of submissions have been made to this Committee from lots of organisations. Is part of the point you are making that there is not a coordination between organisations, or that there is a duplication of the services provided by those organisations? Do they not talk to each other?

Ms BATCHELOR: We absolutely need more coordination, particularly at the level of government. I know in terms of the services we run on the ground, they talk to each other. Our services talk to headspace and we talk to Lifeline, et cetera, but in terms of coordination we need to ensure that every geographical location is covered and every different child is covered and has somewhere to go. I am talking about a situation where when we have a long waiting list for headspace what do we have instead? I am not sure that that kind of coordination happens. More of that would help to ensure that there are services available.

The other thing I want to add is that suicide is not a mental illness and many young people who think about suicide do not have a mental illness. We often tend to focus on the mental health system. I think Mr Woodward mentioned this in his opening statement. There are so many situational factors that lead to a young person thinking about suicide. They need non-clinical, holistic support that addresses those issues, not just the mental health specifically.

The ACTING CHAIR: In terms of the way your organisation operates, are you able to identify regional areas or metropolitan areas where there is a specific need for additional services to be provided?

Ms BATCHELOR: Not from Kids Helpline, unfortunately. Tracy might want add something on this. Kids Helpline provides an anonymous service. Many children do identify themselves but many do not. So, we

do not know where many of our contacts have come from. Obviously, we are only hearing from the young people who choose to call Kids Helpline. There are many more out there who do not. We cannot speak about prevalence issues in particular areas.

The ACTING CHAIR: So you do not have any eyes on whether you are getting a call from Wagga Wagga or Armidale or—

Ms BATCHELOR: In some cases we do, but not in all.

Ms ADAMS: If the young person chooses to disclose where they are from or give advice about what postcode they are calling from we can and we do provide State-based data. We can certainly draw data from the local government regional areas. As Ms Batchelor has highlighted, many of the young people choose to remain anonymous. For them it is a significant breakthrough even to have sought help. They are almost creating an environment of safety for themselves. The young person can continue a relationship with Kids Helpline so that over time they often disclose more and create that trusting relationship, as Ms Batchelor has said.

We would say generally that there is not one particular postcode or region which has a greater prevalence of suicidality. This is one of the key contexts. This is a community issue across all of the communities that we are operating in. There are certainly strong referral pathways to link organisations together, where a virtual service such as Kids Helpline can connect a young person with a face-to-face service provider and be the safety net for face-to-face service providers who cannot be there 24 hours a day. But virtual services, like Kids Helpline or Lifeline, are available to create a space of comfort and security for young people who have significant needs.

Ms BATCHELOR: Can I add that that is a key strength of virtual services like ours—we can reach any location as long as young people have a phone or access to data. The fact that they do not have to identify themselves helps to overcome that problem of stigma.

The Hon. PAUL GREEN: When you talk about referrals and you are able to link them with someone, how do you follow up whether they did or did not, knowing that they may be in acute need of such services.

Ms ADAMS: Sometimes those referrals take place in a three-way contact, with the young person remaining on the line, for instance, and the counsellor making a soft introduction. If the young person agrees with that and wants to participate in that, that can also include connectivity with parents—with them coming into the conversation—if the young person and the counsellor have deemed that they would like to bring them in. When there are significant duty of care interventions, which may require an ambulance or police, we know the result of that contact being made. So there are a lot of connections made.

The Hon. PAUL GREEN: Can you just run through that? You were talking about the duty of care. That is interesting. What does that look like from your side of the phone or the virtual service?

Ms ADAMS: Through any of the virtual programs, telephone or online, there is a relationship with the counsellor, and the counsellor may have deemed that that young person is at immediate risk. You can see in some of our data sets that a young person has contacted the counsellor at the point of attempting to take their own life or doing significant harm to themselves. The counsellor will deem that the risk to that young person is extreme. They will then, with the support of a senior counsellor, contact ambulance or police to undertake an immediate intervention to attempt to support that young person and save their life. We know that that happens quite frequently. We get follow-up from families as a result of those interventions.

The Hon. PAUL GREEN: Do you have some data on that. You said that it happens. Can you back that up with evidence about how many times you have intervened?

Ms ADAMS: Yes, we have data on duty of care interventions specifically. We can certainly provide that to you.

The Hon. PAUL GREEN: That would be helpful. You talk about data that you obtain from Kids Helpline. Do you share this data with any other research organisations or government agencies? Do you have alliances?

Ms ADAMS: We certainly provide the data as much as possible to anybody who contacts us. In fact, we provide a lot of data to government in reporting. We work with universities. Often we are sharing data with other organisations as a means of building up the real framework or fabric of the issue. The data is made readily available. We are often sharing it with local members of Parliament who want particular data sets around their local government areas, for example. Kids Helpline has gathered data for 26 years, and so we have a significant amount of data in measuring trends, as do Lifeline. And many times the data sets will come together.

The Hon. WES FANG: You have provided some data in table 2 of your submission that I found quite fascinating. Being an anonymous program, if a young person rings up and wants to remain anonymous, how does that data get captured if they just want some advice? Are you able to use any of the data sets like phone numbers or dial codes so that you can establish more data? Or do they just get put in an unqualified column? How does that work?

Ms BATCHELOR: Do you mean in terms of identifying if the same individual is ringing multiple times?

The Hon. WES FANG: For example, I am from Wagga Wagga and we have an 0269 area code. If somebody rings from that area, does that then get grouped into "rural and regional"? I note you have rural and regional remoteness scales.

Ms BATCHELOR: Yes.

The Hon. WES FANG: Does that data get captured? Or if they wish to remain anonymous, does their data not get captured at all?

Ms BATCHELOR: Our phone system does have the capability; we are able to do that. I do not think we do that as a matter of course. Mostly all we can report on is the young people we know about. There is always a caveat around our data of saying, "This does not indicate prevalence." We cannot say, "because 10 per cent of our calls came from regional areas". But what we can say is it shows that there is need in all those different locations and from all these different age groups, because we are definitely receiving contacts from all of them. It varies. In terms of gender, we know the gender of most young people who contact, because that is easy. In terms of postcode, it is somewhat less.

The ACTING CHAIR: Is there a gender difference?

Ms BATCHELOR: About 80 per cent of contacts come from females. That is regardless of the issue, and that is fairly standard across most things. Young girls are much more likely to seek help on any issue than are young males.

The ACTING CHAIR: How do we get to young males?

Ms BATCHELOR: Anyone have an answer to that question?

Ms ADAMS: That has been, I guess, an ongoing challenge for us since we started Kids Helpline.

The ACTING CHAIR: The suicide rate amongst males appears to be higher than amongst females.

Ms BATCHELOR: Yes.

The ACTING CHAIR: That is perhaps because females seek help whereas the males do not.

Ms ADAMS: That is right. More young women seek help on the issue of suicidality than young men, and more young men, unfortunately, do take their lives. We have continued to look for ways to elevate help seeking, to elevate awareness. I think it is fair to say that at this point in time there has been little that has made significant changes in that space. It is a space that we are really looking to work with others about how we can continue to be raising that, encouraging young people. When we introduced online counselling and continue to use digital tools—I think SMS has indicated that that may be another channel that young men will use—we had hoped online might be a pathway because of the anonymity associated with it, but we continue to see the same levels of engagement as we had prior to that.

The Hon. PAUL GREEN: How many counsellors do you have manning phones, and what are their qualifications?

Ms ADAMS: Kids Helpline? They are all paid, tertiary-qualified professional counsellors, and currently we have 110.

The ACTING CHAIR: And Lifeline?

Mr WOODWARD: In terms of the training, Lifeline provides training to the crisis supporters under the Vocational Education And Training system. So each of the accredited crisis supporters has several statements of attainment under the Vocation Education and Training. We use our own training program, so our model of service delivery is around crisis support. It is not a counselling qualification; it is a purpose-built model of service, and the training program relates to that. But the training is accredited and people are issued with statements of attainment for the completed subjects.

The Hon. GREG DONNELLY: My question relates to Lifeline and to yourtown separately. Starting with Lifeline, how many telephone services are you aware of that operate in New South Wales or are available to young people in New South Wales who are facing a suicide crisis? What are the choices that exist, if I could use that phrase, for telephone contact in New South Wales?

Mr WOODWARD: In New South Wales, as for the rest of the country, there are two crisis helplines: Lifeline and Kids Helpline.

The Hon. GREG DONNELLY: They are the two?

Mr WOODWARD: They are the two, and they are the two that are specifically crisis-oriented, equipped to deal with suicidal crisis and respond effectively, and to provide a model of service that is around a short time-limited contact with the person. There are a multitude of other telephone, online and other what you might call digital services that may relate to mental health issues particularly, may relate to other issues such as addictions or drug and alcohol use, a whole range. I am sure the Ministry of Health can give you some numbers for New South Wales. It is perhaps worth, though, just commenting on that for a moment. The use of telephone, online or digital services—including now the emergence of text and messaging—has been one of the areas of service development that many people have recognised as being fruitful for reaching young people. If I could refer—

The Hon. GREG DONNELLY: In crisis?

Mr WOODWARD: In crisis, and at earlier stages of their help seeking. In other words, it creates a mode of convenience that has attractions for people seeking help. And therefore, in terms of outreach to young people, there is real potential. I would like to refer to some research work that we undertook a couple of years ago in relation to the Lifeline online chat service. Online chat is a web-based service and people can access that from a mobile device or a computer. We surveyed 238 users of the chat service who agreed, by consent, to be part of the research study. We discovered that half of the people using chat came from ages under 24 years of age, so it is a service that has very much reached out to young people. In contrast, our telephone service 13 11 14—one in 10 of the calls to that service are from people aged under 24.

With the chat service, we also discovered that half of those contacting the service stated that they came from regional or rural areas in Australia. So, again, it is a service that has been able to reach people outside of the metropolitan areas and, conceivably, where they are having particular issues around help seeking or difficulties accessing other services. Almost half of those who came to the chat service stated, when asked, that they were feeling suicidal at the time of the visit to the chat service. This statistic is replicated in other online chat services internationally—that they are services that will attract people in significant crisis. We also discovered that one half of the people who had visited our chat service were given a referral to another service and suggestions for where they could seek further help at the end of the chat session. When surveyed, 75 per cent of those who had been given a referral confirmed that they had actually been to another service. We asked for the listings of the services that they approached and, with interest, noted that many of those services were also digital services.

In relation to your question around the array of services that are available in the digital world—phone, online, messaging, text and so on—there is a growth in those services in this country. They are relevant to young people. It is possible to see the array of those services forming a system or a network that can provide a whole range of service responses, from an immediate crisis response to a person seeking help as a first point of contact—such as Lifeline and Kids Helpline—through to services that can provide more ongoing supports, including treatments in clinical programs. The Federal Government has recognised the growth of digital mental health services in the last few years, and in the last year established the digital mental health gateway, which is known as Head to Health, as a single online location where people can find out more about services that are available. Statewide there is a commitment, we know, from NSW Health to the use of digital mental health services and there is across the primary health networks in regions across the State a similar commitment. These services have real potential in reaching young people and therefore really need to be seen as part of the overall service response.

The Hon. GREG DONNELLY: My question was going to this point—and it is not a trite point but one I am trying to understand—if there is a young person at crisis point, is it generally understood that these are the two best places to go to, as in the ones that have a reputation, credibility and a background in being able to assist them at that time? How does a young person—I noted some of this tracks back to people who are younger than 10 years of age—know where to go? If a seven-year-old is having suicide ideations, I find it hard to grasp how they would work out who to contact.

Mr WOODWARD: I might respond and then let Kids Helpline colleagues respond about some of the age-specific factors. Interestingly, Lifeline, with Orygen, has been developing a program for schools called safeTALK in schools, which is a short workshop but it is embedded into school welfare programs to provide awareness raising for young people around the issues of suicide and to encourage help seeking, including peer-based leadership in help seeking, and to address issues in their lives.

Part of the research work we did in a pilot study at Alice Springs on this program involved asking people about the barriers they saw to seeking help. Interestingly, the most frequently nominated barrier was concerns around what the adult world's reaction might be, and the least frequent response was, "I don't know what services to contact." It needs to be put into context that the issue for many people is not an absence of knowledge around what services to contact: There are other barriers to their help seeking. The primary one, at least in our research—and, I suspect, from Kids Helpline studies and the Kids Helpline—is concerns around the reaction of the adult world to a disclosure.

The Hon. GREG DONNELLY: That is very interesting.

Ms ADAMS: I think the important point is really understanding that the first contact becomes critical—whether that contact is a parent, a teacher, the general practitioner [GP], a peer—and ensuring that, as a community, we know how to respond. If that initial response is not one of being able to support and is not a positive experience, that will shut down help seeking into the future. Young people have shared that in the research that Ms Batchelor has undertaken. For example, when we do brand research we know that young people have a very high recall for Kids Helpline and we too have a program called Kids Helpline @ School that is available to primary schools right across the country. It is about normalising help seeking. It is about introducing counsellors into the classroom to create this.

I think the point is well made by Mr Woodward: it is not necessarily that they do not know Kids Helpline or Lifeline or other agencies but how important that very first contact is that sets the tone. We know that often when we think about who is given training and who is given support, parents are not included yet parents can be the most critical relationship for a young person on this issue. How do we help and support parents to be able to manage when this conversation arises? As a parent, it is extremely difficult, but they are not often considered when we think about gatekeeper training and who is given support and training.

Ms JODIE HARRISON: That actually has led directly to my question about gatekeeper training. Both Lifeline and yourtown have identified gatekeeper training in your submissions. I am interested in knowing how a gatekeeper should be identified. Is it opt-in training? Is it a case of, "That person holds that position and they are a gatekeeper and they have to do the training"? How is that training provided?

Mr WOODWARD: Just as an overall comment, gatekeeper training is generally recognised in the field of suicide prevention as an effective strategy for reducing suicide deaths and suicide rates in a whole-of-community context. In other words, training people who may be in a position to be alert to someone's suicidality and disclosures around their distress and equipping those people to make an effective and immediate response is part of any good strategy for suicide prevention. In terms of the definition of "gatekeeper", traditionally it has referred to health professionals, particularly those in primary health care such as general practice. However, "gatekeeper" can be seen more broadly. When we think about young people, it should be seen more broadly because a young person may choose to disclose their feelings of distress or struggle, including any feelings of suicidality, to the person they trust. They will not necessarily carefully assess which health professional or which adult person they should talk to. They will go to someone they trust.

Furthermore, young people are as likely to disclose their distress or their suicidality to their peers as they are to the adult world. In that sense, when we talk about what sort of training or capacity building is required for youth suicide prevention, we need to think not only of the adult world but also of peers. That is why, with the safeTALK in schools secondary school program that Lifeline is developing with the input of Orygen, we have given particular attention to equipping and promoting peer supports as a way of channelling help seeking. This is part of how we see the overall mix. However, I will add one other thing. Another attribute of youth suicide prevention's gatekeeper training should be to think carefully outside the health paradigm because many of the young people who are experiencing difficulties are as likely to be in contact with child and family service workers, Juvenile Justice workers and other people who come into contact with their lives as they are with health professionals. The idea of training for youth suicide prevention in terms of gatekeepers needs to be seen far more broadly.

Ms JODIE HARRISON: Are those people likely to be considered or trusted by children, that is, Juvenile Justice, and Family and Community Services?

Mr WOODWARD: Again, it depends on the individual situation and it is about trying to cover things. Some years ago the Queensland commissioner for children undertook some analysis of child death and young adolescent deaths by suicide and discovered that more than a third of those who had died were known to child protection authorities. To my mind, that leads to the question: Why not be training child protection workers and child welfare counsellors, student counsellors and so on to be alert to the issues around suicidality and equipped with the basic skills to explore and ask about that? Possibly there are times when they will be the first point of contact for a person seeking help or at a critical time. I think it is about spreading the gatekeeper training programs widely so that you are picking up a whole range of avenues for a young person to seek help.

The ACTING CHAIR: Ms Batchelor, do you wish to add something to that?

Ms BATCHELOR: Firstly, I would like to agree with everything Mr Woodward has just said, but just expand a little bit. Sometimes I actually have a problem with us talking about gatekeepers because it kind of implies that there is this group of particular people out there, and there is not when it comes to children and young people. They could talk to anyone. Secondly, families are forgotten as gatekeepers. Children spend more time with their families than with anyone else. Also there are two sides to it. Yes, there are young people disclosing to a trusted person whom they know, but then there is also the need for people, adults, to notice that something does not look quite right and be proactive and ask the young person. Many young people have said to us, "I really, really want help and sometimes I am hinting at how I feel. I'm hoping someone will notice and ask me and if they asked I would tell them, but I just can't get the words out on my own." We need to focus on that side of it as well. It is not just knowing how to respond if a young person discloses; it is noticing, caring and doing something if someone notices that a young person is going through a tough time and is struggling.

The ACTING CHAIR: There is a lot of interest in the relationship between social media and bullying young people through social media. What does your experience indicate is the extent to which there is a relationship between bullying on social media and youth suicide?

Ms BATCHELOR: If I go to our Kids Helpline data, our counsellors can code up to four concerns that a young person chooses to discuss when they call. If we look at what else a young person talks about when they are talking about suicide, the number one concern is family relationships, regardless of the young person's age. For the younger cohort—the 14 and unders—the second most common issue is bullying. That is not necessarily cyberbullying online, but bullying. The third most common concern is child abuse. I would like to put that in context, not to say that bullying is not important—it certainly is—but family is surrounding most of what we see.

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

Ms ADAMS: Certainly, we take the view that online behaviours relate back to respectful relationships—what they look like and what shape and form they take. We try to focus on how we are enabling young people with the skills to have respectful relationships. With the behaviours that we see online that are detrimental to young people's wellbeing, sometimes the relationship between the bully and the bullied can be a very difficult one. It comes back to how young people are managing their relationships and how we as a community are managing our relationships. It is not only our children who behave poorly online; many adults behave very poorly online. We should not lose sight of that in the overarching conversation about online behaviour.

As adults, we need to ask what the role modelling is, what the relationship is, and how we are using online mediums. At the moment, the focus is on the poor behaviour of children and young people. As Ms Batchelor said, we have seen many strong positives come from young people's engagement with the internet, such as help seeking and caring about others. Young people have the ability to look for and find appropriate good resources to inform them, and they find them on websites that they know and trust. I hope we, as a community, do not get out of balance when focusing on what are good and what are not good online behaviours.

Mr WOODWARD: I completely concur with what my colleagues from Kids Helpline have said. Their comments reflect Lifeline's observations as well. If I can add one further point of exploration, we also see, both on our phone service and chat service, that it is the family and relationship issues that are appearing most often as the key point of the crisis in these young people's lives. There are other things that might flow from that. The other thing to say is that when discussing the online world and social media there is an issue around what the adult world is providing for young people. There is sometimes irresponsible use of social media and

the broader media by the adult world, particularly in relation to portrayals of suicide and suicidal behaviours or stigma-related material around mental health and wellbeing. Those things are highly counterproductive. Conversely, if there are positive messages put out in social media and the wider media world, then those will be positive. Again, there is an issue around what the adult world is able to do.

The ACTING CHAIR: This has been very informative. I appreciate you all coming in. If we have any further questions that we would like to ask you we have a protocol for sending questions. Are you happy to answer those questions on notice?

Ms ADAMS: Absolutely.

The ACTING CHAIR: I thank the representative of Lifeline and—what is the correct name of the other organisation?

Ms ADAMS: yourtown.

The ACTING CHAIR: Sorry. When did the organisation change the name to yourtown?

Ms ADAMS: We have had Kids Helpline as its own brand since we started the organisation 26 years ago. The organisation was called BoysTown until a few years ago. But we have always had the Kids Helpline brand.

The ACTING CHAIR: Thank you for being here this morning. We appreciate the evidence you have given.

(The witnesses withdrew)

FIONA SHAND, Senior Research Fellow and Research Director, LifeSpan, Black Dog Institute, affirmed and examined

BRIDIANNE O'DEA, Research Fellow, Black Dog Institute, affirmed and examined

The ACTING CHAIR: We are now joined by witnesses form the Black Dog Institute. I thank Dr Shand and Dr O'Dea for being here this morning. Have you received an information pack in respect of giving evidence before the Committee?

Dr SHAND: Yes, we have.

The ACTING CHAIR: Thank you. I invite you to give an opening statement to supplement your submission to this Committee.

Dr SHAND: Let me start by saying I am pleased to have the opportunity to appear before the inquiry on behalf of the Black Dog Institute. Our written submission to the inquiry refers to some of the research we are doing, and, if I may, I would like to briefly address some of the strategies that we believe will reduce youth suicide. A model for youth suicide prevention could be developed using the LifeSpan integrated suicide prevention framework. LifeSpan is a framework of nine evidence-based strategies implemented simultaneously within a region. Based on international research, LifeSpan is predicted to reduce suicides by 20 per cent in the general population.

The Black Dog Institute is driving the LifeSpan research in four regions in New South Wales covering a population of 960,000 people in total. We are also providing support to 12 Commonwealth funded trial sites, some of which are targeting particular at-risk groups such as Aboriginal and Torres Strait Islander people or the lesbian, gay, bisexual, transgender, queer or questioning, intersex [LGBTQI] community. Universally delivered school-based suicide prevention programs could also be rolled out. There are some strong evidence-based programs such as Youth Aware of Mental Health [YAM] for high school students, and the Good Behaviour Game for primary school students. Both of these programs have demonstrated—amongst other positive mental health and behavioural outcomes—reductions of up to 50 per cent in suicidal thinking and behaviour amongst young people. The New South Wales Department of Education has invested heavily in YAM for high schools, and it has now been delivered to over 5,000 year 9 students in our first two LifeSpan trial sites.

Greater use of technology, as referred to by the previous speakers here, such as apps, online treatment and screening programs, could also be rolled out to reach those young people who are not currently seeking help for their distress. Online treatment has proven effective for treating and preventing depression, and indeed has proved to be as effective in adult populations as face-to-face treatment. We are currently trialling an online stepped care clinic in several New South Wales high schools called Smooth Sailing, led by Dr Bridianne O'Dea. It allows for detection of symptoms of anxiety and depression, for tailored treatment and for ongoing monitoring of these symptoms for the students. These are school programs that could be taken to scale quite quickly. Strategic investment in the use of social media can assist to identify those at risk of suicide and to intervene. Our work has shown that an individual's social media content may indicate their suicide risk and provide a window of opportunity to intervene and prevent death.

Social media may also be a viable delivery method for anti-stigma and pro help-seeking campaigns to combat two major barriers to help-seeking. There needs to be significant investment and incentive for policymakers and social media companies to investigate and harness the potential of this medium for suicide prevention. Finally, we need both improved data and better access to data in order to plan suicide prevention activities and to measure progress and impact on youth suicide. Through the LifeSpan project we have developed a system for cleaning and analysing coronial, ambulance and police data and with the capacity for more data sets. There are substantial barriers to obtaining and using these data but these are not insurmountable.

We have also partnered with the Australian National University to build a geospatial mapping capacity for suicide, which can produce maps—such as some here that I would like to tender. This technology can be used to identify clusters, means and age groups most at risk within a region to assist with planning prevention activities. There are really five key areas where I think we could be making a difference to preventing youth suicide and that is really those ideas of using an evidence-based, community-wide framework for suicide prevention; investing in universally delivered school suicide prevention programs; the use of technology; harnessing social media; and improving access to data in order to improve planning, service delivery and evaluation.

The ACTING CHAIR: Do you wish to table those maps?

Dr SHAND: Yes, I have them here.

The ACTING CHAIR: We heard from an organisation called 3rd Degree, which, with the consent of families, provides a monitoring service on everything that kids are writing at schools. Computer use at schools is monitored by them and they look for key words. They cannot identify a student by name but they can identify a student by number, which they then pass back to the school when they identify potential trigger words. Is that the sort of technology that you would embrace?

Dr SHAND: I have seen the 3rd Degree program. What I am not aware of is what the evidence suggests about it. I guess I would be reluctant to recommend a technology that has not been fully evaluated and where we do not have good evidence that it actually is acceptable and it does actually prevent suicide.

The ACTING CHAIR: I am not asking you to endorse their product. I am asking you in general terms about the concept of whether data should be collected in some way or another by external organisations to be able to monitor what young people are saying in their day-to-day life in the school environment?

Dr SHAND: That can happen in a number of environments, including on social media. I might refer to Dr O'Dea to respond to that question as well.

Dr O'DEA: In part of my research one of the things that I do is look at how we can use social media to detect suicide risk, and the way we do that is by monitoring your linguistic style. That is not necessarily the words you say but how you say things. This has been demonstrated to be quite an accurate signal of when somebody is suicidal. It comes not only from what you say on social media but also from how you talk in clinical interviews. It is really about the way you talk. We have done research which shows that you can find certain linguistic markers and some of those things are emotional markers, such as anger. But the most prominent one is use of the first person pronoun. When someone uses the word "I" that can be a really strong indicator of how at risk they are of suicide. That sums up how we monitor social media and language. In the school context, I have been working in schools for five years now and one of my hesitancies about that sort of technology would be the level of autonomy and independence that it fosters in young people.

One of the reasons that young people have such a hard time seeking help—as we did hear before—is they are at an age where they really want to assert independence and autonomy over their own health, and really they are growing up. One of the struggles I think about getting that type of technology out to the hundreds of thousands of young people that you would need for it to take an effect on prevention would be that they would see that as a big brother effect. It does not encourage them to be more mindful about what they are doing. In fact, it has that overarching effect. My experience with the most disadvantaged youth in communities that have high suicide rates is that they lack a lot of trust in the adults around them, and they lack a lot of trust in their school. So I think we would face implementation barriers to getting that sort of technology out there, despite the good that such technology could do.

The ACTING CHAIR: You were in the room when I asked people from Lifeline and Kids Helpline about social media and bullying in social media. Their response was that the emphasis which we had appeared to give in day-to-day conversations to bullying and social media was not nearly as great. I hope I am not misrepresenting them. Is that your understanding as well?

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

The ACTING CHAIR: You would agree with them that often the family crises and circumstances in their family background are a much greater indicator than potential bullying in social media?

Dr O'DEA: Yes, that is correct. That is not to say we do not need to do something about bullying and social media, but in the greater realm of prevention family relationships are worthy of a lot more attention.

The ACTING CHAIR: I have always associated the work that the Black Dog Institute does with people who suffer with depression.

Dr SHAND: Traditionally that is correct. About five or six years ago Helen Christensen, who was the director of the Black Dog Institute, was awarded a National Health and Medical Research Council grant for the Centre of Research Excellence and Suicide Prevention.

The ACTING CHAIR: I know of it.

Dr SHAND: We have moved into the suicide prevention realm in the past five to six years. It is a big part of our work now.

The ACTING CHAIR: I am interested in the link between depression and youth suicide. Would you make that link?

Dr SHAND: They are definitely linked, but sometimes that link is overstated. One of the things we know about young people in particular is that they are not always suffering from depression when they attempt suicide. Young people have greater fluctuations in their emotions and are more likely to have rapid onset despair or high levels of impulsivity, particularly combined with alcohol use. In that case, there is a catalytic effect. It is not always about depression, but it is certainly one of the big risk factors. School-based programs focused on the prevention of depression may well be effective. Online programs used to treat insomnia or depression in the older population also have an impact on suicide risk.

The ACTING CHAIR: The Committee has also heard evidence about the cluster effect of suicide among young people. Has any of your research looked at the relationship between one young person committing suicide and the cluster effect?

Dr SHAND: No, I cannot say that contagion is one of the areas on which we have focused. We are aware that that effect exists, but it is not something we have focused on specifically.

The Hon. WES FANG: Can you provide the Committee with an update on the implementation progress of the LifeSpan program across your four sites in New South Wales?

Dr SHAND: The program is being rolled out in a step-wise fashion. We now have three of our four sites in the implementation phase—that is, they are in the first year of implementation—and the fourth site is in the planning phase and goes live on 1 April. Newcastle was our first site, followed by the Illawarra/Shoalhaven, followed by the Central Coast, and Murrumbidgee starts on 1 April. Each site is at a slightly different stage of implementation. As members can imagine, with nine strategies there is a great deal of work to be done. Three of the four sites now have a crisis and after-care service in place. We have started rolling out the Youth Aware of Mental Health [YAM] program in schools in two of the four sites. As I said, about 5,000 students have been through that program.

The ACTING CHAIR: Does that involve training people within the school environment, or do you go to schools to deliver the program yourselves?

Dr SHAND: No, we do not. We have master trainers who have been trained by people from Europe who own the program. The Department of Education has committed funding to employ some of those master trainers. One of the YAM guidelines is that it is never the teachers who deliver, it is always an external master trainer. They work with the students doing role plays aimed at getting people to support each other, being aware of their own mental health, and so on. It is very much driven by the master trainers rather than the schools. However, to support that, we have developed a training program for school counsellors because part of the program means that young people at risk might be identified. We wanted to be sure the school counsellors were well trained to support those young people.

Ms JODIE HARRISON: You made a comment about the need for after care and how LifeSpan is dealing with it. What is the Black Dog Institute's view of how good we are, or not, in regard to postvention? We know that the most risky time is the seven days after an attempt.

Dr SHAND: Yes.

Ms JODIE HARRISON: What is your view about how we deal with that in New South Wales?

Dr SHAND: There are some hospitals where the response to a person in crisis is strong and others where there is certainly room for improvement. We think about it in two stages. There is the first response when the person turns up to the emergency department or is picked up by a paramedic. The ongoing care they receive after that is critical. As a previous speaker said, we know that that first response is critical. If people receive an empathetic and effective response at that first point of contact, they are much more likely to seek help if they are in trouble again down the track.

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

Ms JODIE HARRISON: Is that postvention as important for young people, particularly where the attempt was as a result of impulsivity and not a mental health issue?

Dr SHAND: I think it is. First, we often see that impulsivity is comorbid with a bunch of other problems such as substance use and other behavioural disorders. They clearly need to be addressed in the after-care strategy. We also know that impulsivity is a risk factor and that part of that is likely to be some emotional dysregulation. Again, those things need to be addressed in the intervening weeks. We also know that, as suggested, during that first week people are often feeling raw and not sure where to go. They often do not remember much of what was said to them in the emergency department setting. Having someone make contact with them in that first 24 hours and in the first week is critical, irrespective of age. In fact, families often tell us about the incredible difficulty they have in navigating what is a complex health system. They are falling between the cracks and cannot find the right services. Part of that after-care service needs to focus on care coordination. They need someone to help them to find the right services. If the first service approached is not the right one, they can direct them to other services.

Ms JODIE HARRISON: Mention was made of the ELEM/Youth in Distress program, which involves training school counsellors. One of the issues addressed in that training program is how comfortable school counsellors feel in having students returning to school after a suicide attempt or self-harm and being able to care for them. It is a healthcare system issue, but how do schools feel about returning students to a happy and healthy environment?

Dr SHAND: When it comes to younger people, most after-care services will do their best to involve the family in providing support to the young person.

The Hon. GREG DONNELLY: Thank you for appearing before the Committee today. The Black Dog Institute, headspace, the Kids Helpline, and Lifeline have a very high profile and are well known for doing a lot of excellent work in respect of youth suicide, and particularly prevention. What if any structures or relationships have been established across the four organisations to ensure there is no overlap or repetition of services? Having read the submissions to the inquiry, I cannot help but note overlap in some areas. I will be provocative in respect of your organisation by saying that once upon a time you were not involved in this area, but obviously you are now. That is not a bad thing; it is the reality. My concern relates to this constant need for the State—as in the government of the day—to provide support and resources to organisations to do this important work but finding there is overlap and, dare I say, a repetition of the work being done.

There is always the argument "ours is a slightly different research methodology from someone else's". We can split hairs, but it seems to me it is a real challenge as we look ahead. Because there is a real determination to deal with this serious social issue for young people, what guarantees, dare I use that word, can the State ask for that we are not—this is either at a State or a Commonwealth level, or a combination of both—providing resources where overlap is taking place?

Dr SHAND: I can see that is a really difficult position to be in. Speaking to our relationship with ReachOut, Lifeline, Kids Helpline and headspace, Black Dog has traditionally been primarily a research organisation. So rather than being on-the-ground service providers we are much more research focused. For instance, when I look at the LifeSpan program, we are driving the research and we are working with people on the ground who are delivering the services, but we are not delivering the services. That is one important distinction to make. We have worked with Lifeline. We have done some research with Lifeline and similarly with ReachOut and some of the other organisations you have talked about. There is a relationship at that chief executive officer [CEO] level and certainly there have been moves over the past 12 months or so to get better integration at that CEO level amongst those organisations that you mentioned.

When we make recommendations, we always focus on what the research evidence says. That does not mean that the programs that are out there are not effective; it is just that we do not have the evidence to recommend some of those programs that are out there at the moment. If I take the school-based space in the LifeSpan program, what we did was we reviewed the evidence, we came up with three programs which had good evidence for their effects on suicide risk and then we worked closely with the NSW Department of Education, with principals and with schools to say, "Which of these programs is the most feasible for you to deliver?" Then we went with that program. That is the kind of process we go through to recommend a program, but as I said we are not necessarily the providers of those services on the ground.

The Hon. GREG DONNELLY: I use as an example—once again, it is not a criticism; it is just an observation—Kids Helpline, who appeared before the Committee earlier today. In their submission was a table which broke down information. They were asked about whether or not they identified at a postcode level or some other location basis where their calls or interaction over the net come from. It was carefully explained that if the information is forthcoming it is able to be captured but, generally speaking, they do not capture it. In other

words, they have information but it is essentially holistic on a State or a national basis. The material you provided to the Committee this morning has a high level of specificity through your methodology—you can almost pinpoint instances of individual cases or clusters. There seems to be a yawning gap between what you are capable of doing and what you are doing and the things that are in operation. Once again I am not pointing fingers; rather I am just using it as an example of the different approaches being run on an ongoing basis by organisations that are doing work in the same area.

As a mug, I would have thought that your information—to the extent that it can be collected—is far more valuable for trying to deal with the issue with that level of specificity of youth suicide than the broader more aggregated information of Kids Helpline. Why would there not be an attempt to get Kids Helpline to pick up, essentially, either the systems you use—whether it is the programs you use or the methodology you use—to do something at that level of detail? If one stands back and looks at those who are doing the work in this area, from the point of view of the State, at the highest level or through the departments of health or education, one finds that there are areas in which there could be real value in someone getting out of an area and leaving it to someone else who is perhaps doing a better job instead of this not explicit but more implicit or inadvertent competition across some grounds.

Dr SHAND: Yes.

The ACTING CHAIR: That is a long question.

Dr SHAND: I will respond to a couple of bits of that, if that is okay. Certainly those are some of the conversations that are happening at that CEO and senior level around who should be doing what, and I think there is a way to go in that space. In regard to the data, we have had conversations with Lifeline about whether we could get their helpline data.

The Hon. GREG DONNELLY: Can I ask you what "a way to go" means?

Dr SHAND: I wish I could give you a clear answer.

The Hon. GREG DONNELLY: But you can see if I was being hardline I would say that is not very reassuring.

Dr SHAND: Yes.

The ACTING CHAIR: Anyway, keep going.

Dr SHAND: In regard to the data, we have had conversations with Lifeline—those same conversations about whether we could get place-based data, because the suicide deaths are part of the picture but we also need to be looking at where attempts are occurring, where people are most frequently seeking help and where the services are. We are constantly looking for those sources of data so that we can overlay those with the data we already have.

Dr O'DEA: As Dr Shand said, Black Dog Institute is a research institute. We are both research fellows and we are both associated with the university so that the work we are doing is always subject to publication and peer review. So we do have a research perspective to all the work that we take. We would easily and willingly evaluate all available programs—we do not have allegiances to any programs—but what we have found in our experience is that a lot of the programs that would work best have not been designed and so we have had to go and design them.

The Hon. GREG DONNELLY: And a lot are not well evaluated.

Dr O'DEA: Precisely. We share those same frustrations because, coming from a research perspective, we preference number one as evidence based. We are always happy and willing to support what is evidence based but unfortunately in this space there is still a lot of work—when we say "a lot of work" it means a lot of research trials—and a lot of investment in conducting high quality research. Again on the point about the postcodes, we share the frustration in that there are many data sources out there that we cannot get access to that can help inform where services should be delivered and what type of services. Part of our submission was around thinking about an evidence-based service provision—using these types of data, these maps, to identify where services should be provided and who should be providing those services. A lot of it is still questions that have to be answered.

The Hon. GREG DONNELLY: From the State's point of view, should we get the key players in the room and knock heads together? I am being a bit provocative here. This is a very big social issue. We all are wanting to do what we can to either eliminate it completely or significantly ameliorate it. But we have to ensure we do not have some of these issues and that we are doing something more formalised than the CEOs getting together on an informal basis—and I do not say this disrespectfully—and talking about what respective

priorities might be to try to get greater differentiation of work that is being done and specialisation so we are getting the maximum output and the most effective work done in whatever respective area the organisation has a comparative strength.

Dr SHAND: I am not sure I am best placed to answer that question about the way to proceed, but certainly there would be benefit in getting some coordination. Getting some of the key players in the room with a clear agenda could be beneficial.

The ACTING CHAIR: Representatives of the relevant departments are appearing at the hearing this afternoon. Perhaps that is a good question for them. Do you get access to data from, for example, the Coroner's office?

Dr SHAND: Yes. The maps I provided are based on the coronial data. There are substantial ethical applications that we need to go through to get access to those data and we can only provide them on an aggregated level. We have restrictions around how we can use those data.

The ACTING CHAIR: Dr O'Dea, you said there are problems accessing some data. Where are the problems or roadblocks in relation to you accessing data?

Dr SHAND: Some of the data do not exist in a useable form. For example, emergency department [ED] data is not routinely coded. When someone presents following self-harm or a suicide attempt there is no requirement for the ED to record that that is the case. So there is a big gap in the knowledge of who hospitals are seeing and what they are seeing them for in this space. The data are there but they are not particularly good quality for our purpose. The other gaps would be with respect to the workforce data and the service provision data.

The ACTING CHAIR: Some of the evidence we have heard is in relation to the nature of family and the support from family. Do you get any access to Family Court data?

Dr SHAND: No, and I am not sure that we are able to. Dr O'Dea, do you know?

Dr O'DEA: No.

Dr SHAND: No; I am not aware of any routinely collected data that we would be able to access.

The ACTING CHAIR: It is two minutes to 12, and unless anyone else has any more questions—

The Hon. GREG DONNELLY: No, it has been very good.

The ACTING CHAIR: Your evidence has been very helpful. Thank you for coming in. As you probably heard me say before, if we have any additional questions that we want to put to you in writing arising from today's proceedings are you happy to answer those?

Dr SHAND: We would be very happy to respond.

(The witnesses withdrew)

(Short adjournment)

SARAH LAMBERT, Director, Community Health and Regional Services, AIDS Council of New South Wales, affirmed and examined

TERENCE HUMPHREYS, Co-executive Director, Twenty10, affirmed and examined

CRISTYN DAVIES, Co-chair, Twenty10, sworn and examined

The ACTING CHAIR: We are now reconvening the Committee on Children and Young People conducting an inquiry into suicide of young people. I welcome Sarah Lambert from the AIDS Council of New South Wales and Cristyn Davies and Terence Humphreys from Twenty10. I take it you have received an information pack relating to giving evidence here today.

Ms DAVIES: Thank you.

The ACTING CHAIR: You have been sitting here, I think, this morning and you have heard other people give evidence. Is there an opening statement that you would like to make in support of the submission?

Ms LAMBERT: The AIDS Council of New South Wales [ACON] welcomes the opportunity to provide input to the Committee on Children and Young People on the current approaches aimed at preventing youth suicide in New South Wales. We recognise that youth suicide has a lasting impact on friends, families, schools and communities. It is well documented that young people who are gender or sexually diverse face specific barriers to mental health and social inclusion which require tailored suicide prevention measures. I am going to speak about some of the research, as well as the lived experience and practice evidence. We are aware that there is a significant proportion of Australians who have sexual identity attraction and experiences that are not exclusively heterosexual, and the number of people who are not cisgender and have intersex variations requires comprehensive suicide prevention plans for lesbian, gay, bisexual, transgender, intersex [LGBTI] young people.

LGBTI young people are at considerably higher risk, as identified in suicide prevention policies and research. Young people questioning their gender or sexuality may experience mental health issues more severely than heterosexual, cisgendered young people. They, too, experience minority stress and marginalisation, increased risk of depression, anxiety, self-harm and suicide, with the onset of mental health disorders peaking between the ages of 16 and 24, closely followed by the 25 and 30 year age group. This coincides with the critical time for their identity formation.

We know through literature that there is an increasingly high incidence of suicidal ideation with "Growing Up Queer: Issues Facing Young Australians Who are Gender Variant and Sexuality Diverse" finding that 100 per cent of LGBTI young people across the study had thought of self-harm. We know that Aboriginal youth, youth from culturally and linguistically diverse backgrounds, and regional and rural youth have specific needs, and that there are intersections across those populations. Beyondblue points to major risk factors faced by LGBTI people—adjustment to sexual orientation, peer and societal reactions to same-sex orientation, bullying and violence. We refer you to the La Trobe University national study "Writing Themselves In", at page 6 of the submission, where only 19 per cent of young people identified going to a school that was supportive of their sexuality, and over a third described their schools as homophobic.

This is not an insignificant population. LGBTI communities have found that 16.8 per cent of secondary school students in Australia report being attracted to people of the same gender as themselves, or both sexes, and 6.5 per cent of men and 13.5 per cent of women in a sample of 20,000 undertaken by the Australian Research Centre in Sex, Health and Society in 2014 found they were having sexual experiences that were not exclusively with the other sex. While very few studies exist for gender diverse people, a New Zealand study on adolescent health survey, "Youth '12", indicated that 4 per cent of students may be transgender. Organisation Intersex International Australia estimates the prevalence of intersex people to be 1.7 per cent of all live births.

I will paint the picture of what an LGBTI young person faces. A young person may be bullied at school, which could include verbal and physical abuse, exclusionary or isolating measures, and they may not have a supportive home environment. There are high incidences of familial conflict and adjustments, where people experience suicidal ideation. If they access health services it is likely that they are assumed to be heterosexual or cisgendered, so assessments and interventions do not adequately take into account their lived experiences and needs. This requires them to disclose their gender and sexuality, where they may be fearful of negative responses to begin with.

The impact that that might have is that they may not access these services. They may not engage after the initial contact if they do not feel that any aspect of their health is being met. If they do engage, there may not be a holistic response. Often they will need to educate their workers, taking attention away from their own care

and support needs. In rural and regional New South Wales a young person's only option may be the family general practitioner, where they are particularly concerned about confidentiality, and there is not anonymity at health services, with LGBTI youth facing extensive social isolation from support options.

We know from studies that if an LGBTI person has died as a result of suicide they will have experienced coming-out milestones two years early and potentially be living with internalised trans and homophobia. They are more likely to have experienced assaults. They are at 23 times higher odds of having a current depressive major episodes. They are at nine times higher odds of having a previous suicide attempt, and they are more likely to be receiving treatment from a psychiatrist. They are also more likely to have higher substance use issues than LGBTI living controls.

In conclusion, ACON to address these needs— advocates for improved data systems for monitoring; the use of sexuality and gender indicators across all data collections; that LGBTI people are recognised as a priority population with unique needs and this is linked to action in line with lifeSpan; the mainstream services have capacity building beyond training that is systemically built into their policies and systems; that specialty services are provided not only for choice but for practice, leadership and developing the evidence-based approaches to support mainstream services, which is less likely to happen if occurring in general health services; and lastly, within the bullying frameworks, that the Government works with family planning to ensure that LGBTI student needs are built into those programs.

The ACTING CHAIR: Twenty10, do you want to make an opening statement?

Ms DAVIES: Yes. Firstly, thank you for the opportunity to address this important inquiry into the prevention of youth suicide in New South Wales. As I have stated, my name is Cristyn Davies and I am speaking today in my capacity as co-Chair of the board of Twenty10 incorporating the Gay and Lesbian Counselling Service of New South Wales. Together with our peak body, the National LGBTI Health Alliance, we made a submission to this inquiry that provided 27 recommendations, primarily based on research undertaken with LGBTI Australian young people and also framed by the National LGBTI Mental Health and Suicide Prevention Strategy developed and launched by the Alliance.

I draw the committee's attention to additional research reports that support our submission and to speak to the importance of knowledge translation and implementation science. Briefly, knowledge translation refers to the synthesis, dissemination, exchange and ethical application of knowledge to improve health by the provision of more effective health services to strengthen the healthcare system. Implementation science refers to the study of methods to promote the systematic uptake of research findings and evidence-based practices into routine health care in clinical, organisational and policy contexts. Although researchers and other professionals continually produce new findings and recommendations, research alone cannot change health outcomes unless healthcare services and key decision-makers work together to put findings into practice. These processes require adequate planning, resourcing and evaluation as well as broad-based political, institutional and individual support.

The Young and Well Cooperative Research Centre-funded collaborative report, led by Twenty10, entitled "'You learn from each other: lesbian, gay, bisexual, transgender, intersex, queer [LGBTIQ] Young People's Mental Health Help-seeking and the RAD Australia Online Directory 2017" indicated that while all LGBTIQ young people are susceptible to discrimination in healthcare settings, it was commonly noted that young non-binary and transgender people experience greater discrimination and face a greater likelihood of experiencing inadequate treatment from mainstream health services and professionals. Trans, gender diverse and young people with intersex characteristics face greater barriers in accessing adequate mental and general health care and have fewer existing digital tools which can respond to their experiences and needs.

Access to non-judgemental and confidential mental health support was even more difficult for young people living in rural and regional settings and also for young people experiencing intersecting marginalisations. Significantly, LGBTIQ young people rely on peer networks for support and for recommendations of health professionals and organisations. This finding led to the development of the RAD Australia online directory prototype—a digital LGBTIQ friendly and peer-led health service directory for young people aimed at supplementing, not replacing, face-to-face services and support networks.

In the Telethon Kids Institute's "Trans Pathways" (2017), which examined the mental health and care pathways of trans and gender diverse young people in Australia, researchers reported that transgender young people found it difficult to access health services, with 60 per cent feeling isolated from medical and mental health services and 42 per cent having reached out to a service provider who did not understand or respect their gender identity. This is a common theme through all the research reports that we have acknowledged in our submission and in my opening statement today. In this report, problems with health services included: a lack of education about gender diversity; not knowing where to refer transgender patients; transphobia; and long

waiting lists to see healthcare providers who are well informed about gender care and who are transgender friendly.

The preliminary report entitled "Access 3: young people's healthcare journeys", funded by NSW Health and led by the University of Sydney and the University of Technology, explored the barriers and facilitators to healthcare for marginalised young people, including gender and sexuality diverse young people's experiences of navigating the health system in New South Wales over time. This report highlighted discrimination and prejudice, including homophobia and transphobia, experienced by gender and sexuality diverse young people accessing health services. Barriers to navigating iandaccessing the health system included personal factors, such as concerns about confidentiality and embarrassment, and also logistic and practical factors—waiting lists, opening hours, service location, transport and cost—which were further compounded for those residing in regional and rural locations. Cost was identified as the most frequently cited barrier, with 45 per cent of young people identifying that cost would prevent them from visiting a health service. In a peer-reviewed publication recently published in *Health Education Journal*, the Access 3 research team found that:

> a better understanding of marginalised young people's healthcare experiences, including the complexities of multiple disadvantage, and how this contributes to health inequalities could lead to more welcoming and respectful health services. Services can reconceptualise their roles by reaching out to young people, both physically and online, to make the navigation of the health system easier. Marginalised young people's healthcare journeys can be supported by advocates that help them navigate the health system.

The Access 3 report has informed the NSW Youth Health Framework 2017-24, which supports health care that is responsive to the needs of young people. We recommend that this framework is implemented alongside the National LGBTI Mental Health and Suicide Prevention Strategy, which is a plan for strategic action to prevent mental ill health and suicide and to promote good mental health and wellbeing for LGBTI people and communities across Australia. We also support the Darlington Statement, which sets out the priorities including health and wellbeing by the intersex human rights movement. Other relevant documents for health services and professionals working in this field include up-to-date iterations of the Attorney General Department's "Australian Government Guidelines on the Recognition of Sex and Gender", and the Australian Human Rights Commission's "National Statement of Principles for Child Safe Organisations".

The Australian Institute of Family Studies—obviously an Australian Government report—"Self-harm and suicidal behaviour of young people aged 14 to 15 years old" found that young people who reported that they were same-sex attracted, bisexual or unsure of their sexuality were at greater risk of self-harm than their heterosexual peers. Those who reported being threatened or feeling victimised by their peers because of their sexual orientation were at greater risk of self-harm. Further, young people had an elevated risk of suicide if they had self-harmed, were same-sex attracted, bisexual or unsure of their sexuality.

This inquiry will receive many important evidence-based recommendations regarding the health and wellbeing of marginalised young people. Some of these include the importance of data collection for LGBTI young people—see our recommendations 7 to 9; timely and accessible publicly funded multidisciplinary gender care to reduce the risk of suicide, including psychosocial assessments and support, hormone therapy and surgery for transgender young people and support for their families—see our recommendations 13 and 14; timely access to appropriate multidisciplinary clinical and non-clinical mental health services that have expertise appropriate for people with intersex characteristics and their families—see recommendation 15; LGBTI youth-led initiatives and consultations—see our recommendations 1, 3, 4, 18 and 22; targeted and LGBTI-specific training and professional development for health and education professionals in this field—see recommendations 19, 20 and 26; and targeted interventions that name bullying, harassment and violence directed at those who are or who are perceived to be LGBTI at school and other places, both public and private. The effective operationalisation and implementation of evidence-based recommendations requires good political will and adequate planning, resourcing and evaluation.

The ACTING CHAIR: You referred to an app that you developed called, I think, RAD.

Ms DAVIES: Yes.

The ACTING CHAIR: Could you explain how that app operates and how it has been used and accessed?

Ms DAVIES: Sure. Currently it is a prototype, so there was some funding from the Young and Well Cooperative Research Centre, and it needs further development and so we need further funding. It is in its first iteration at the moment. Currently it is a website, although we know that young people use apps so we would like to turn it into an app. Young people recommend health services and physicians and other support services that they have accessed and then other young LGBTI people heed those recommendations. What we have found out and what we know about our research is that a lot of young people are supporting each other, often without

institutional support. This is a way of linking young people into institutional support and also for them to identify youth-friendly and LGBTIQ-friendly mental and physical health services.

The ACTING CHAIR: This is interesting, because we had Lifeline and Kids Helpline in here and they did not identify LGBTI issues as being one of the big factors for their services. Does your organisation offer that sort of access to young people?

Mr HUMPHREYS: We run the New South Wales arm of the national QLife service, which is a peer-led primarily volunteer-run but also staffed LGBTI support line and web chat service. We have seen the number of young people utilising the service, particularly web chat, growing exponentially month by month for several years.

The ACTING CHAIR: Can you give us some figures on that? What is the access rate like?

Mr HUMPHREYS: At the moment we are talking about a third of all contacts, maybe even higher at this point, but certainly the numbers for last year—at least a third of the contacts—were LGBTI young people, and a significant chunk, another third of that, would be in regional and remote areas as well.

The ACTING CHAIR: Is that 1,000 contacts?

Mr HUMPHREYS: I am sorry—I think it is about 50,000 for the year.

The ACTING CHAIR: So, during the year 2016-17, there would have been 50,000 contacts to your site?

Mr HUMPHREYS: Yes.

The ACTING CHAIR: For the purposes of talking about?

Mr HUMPHREYS: Reaching out for help and support around a range of issues but often commonly it is around isolation and loneliness; exploring their gender or sexuality; and relationship issues, particularly rejection from family and peers.

The ACTING CHAIR: Do you have any ability to identify those who are at risk of self-harm in that cohort that accesses your service?

Mr HUMPHREYS: We are not a crisis support or suicide prevention service. However, often young people who contact us, or anyone who contacts us, may be in a state where they are thinking about self-harm or ending their life. All of our staff and volunteers are trying to recognise those protocols and to support them and refer them on to specialised help.

The ACTING CHAIR: Where is that specialised help?

Mr HUMPHREYS: Usually, in the moment of the crisis, that involves contacting emergency services for that person, with their support if possible. Being an anonymous service, we do not have access to their direct location sometimes. We do not take their name and details because it is a confidential anonymous service. It is quite difficult to be able to send support without that contact's willing support in that process. If that is outside of our ability to send that support, then we cannot really change that, but certainly some services, like Lifeline for instance, have the possibility to track that person by their web address and those sorts of things.

The ACTING CHAIR: Do you collect data around this?

Mr HUMPHREYS: We collect data around contacts and the themes of the calls but we do not collect data around information to do with the names of people or their locations necessarily.

The ACTING CHAIR: No. I think privacy would probably prohibit that.

Mr HUMPHREYS: Yes.

The ACTING CHAIR: But in terms of collecting the data about people who are contacting your service, and who potentially are at risk of self-harm, do you collect data in relation to that?

Mr HUMPHREYS: Yes, we do. The number of contacts per year that mention or talk about that, and of course also critical incident reports that relate to that information.

The ACTING CHAIR: How many are there of those?

Mr HUMPHREYS: I could not say off the top of my head, but certainly a handful each year without a doubt—maybe 20 or 30. But I think that in the moment someone contacting us about that is looking for that support whereas, if someone was already feeling bleak, they would not necessarily contact us in that moment. Also it is a limited service. We are not a 24-hour service like somewhere like Lifeline. We are 3.00 p.m. until

midnight and all of our lines and web chat are at capacity in terms of our ability to take them. While our staff or volunteers are on web chat or taking calls, there are other people who cannot get through, so there is a risk attached to that as well.

The ACTING CHAIR: Do you see a problem with services like Lifeline and Kids Helpline in that perhaps they are not trained in delivering or being able to refer people properly?

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

Ms DAVIES: I am one of the authors of the "Growing Up Queer" report, and what we actually found in that study was that young people were more aware of Kids Helpline and Lifeline and those sorts of services, so often they would call them first. Really, depending on the person they spoke to, sometimes they would refer that young person to services such as QLife.

Ms JODIE HARRISON: First, I will make a comment on the results of what is reported in your submission for the "Growing Up Queer" report: that basically 100 per cent of trans people have self-harmed.

Ms DAVIES: Yes.

Ms JODIE HARRISON: We are doing something wrong.

Ms DAVIES: Yes.

Ms JODIE HARRISON: Twenty10 submission's recommendation No. 22 states:

> Support and resourcing for the establishment, development and growth of LGBTI peer led programmes, services organisations and groups supporting LGBTI young people

Does that recommendation take in and deal with the issue of gatekeepers and training for gatekeepers? How would those people be identified?

Ms DAVIES: I am sorry: I am just getting my head around that actual recommendation. We have quite a few here.

Mr HUMPHREYS: Can I just clarify this: By "gatekeepers", do you mean school teachers, school counsellors, GPs or those sorts of people?

Ms JODIE HARRISON: You can tell me, because lots of submissions use the term "gatekeeper".

Mr HUMPHREYS: Yes.

Ms JODIE HARRISON: Obviously it is something that we as a Committee are trying to get our heads around. I am interested in knowing, when people use the term "gatekeeper"—which is a term used in your submission—what that means. What support should be provided? How are they identified?

Mr HUMPHREYS: Depending on the level of support that a young person perceives in their own family and peers, they will often reach out to maybe a friend or a family member—often mum—before coming out and disclosing their identity to that person. Following that, the next person might be a school counsellor or a schoolteacher, who they experience as being supportive or who they perceive as being very supportive. Those people often play a really important role in recognising early intervention opportunities and linking them in with a support service that is appropriate for them.

For instance, at Twenty10 we get a lot of young people who have been referred by a school counsellor or teacher who knows about the service. Those people can then circumvent the family unit if the parents are not supportive. A lot of families are not supportive—in particular, the families of transgender and gender diverse young people, with at least one third of parents not supportive at all. If parents are not looking after the wellbeing of the child the responsibility falls to other gatekeepers, such as a school counsellor, schoolteacher or general practitioner who may be aware of the circumstances. But as we have seen, those young people are often scared to reach out to those people. It is not a safety net that we can rely on, but it sometimes works, and thank goodness it does.

Ms LAMBERT: I would broaden the term "gatekeeper" to include peer networks, which many LGBTI people utilise. Peer networks include others who identify as lesbian, gay, bisexual, trans, and/or intersex,

but also other young people who may not identify as LGBTI. Young people will often feel out of the waters with those people before pursuing other disclosures. Certainly our communities would see peer as being not only those in the physical space but also in the online space, where there is greater anonymity and access.

The Hon. GREG DONNELLY: Thank you for coming along today. I would like you to help me understand a couple of definitions. Forgive me for appearing ignorant, but what definition best describes or explains what homophobia is?

Ms DAVIES: I should probably be referring to a report here, but it is perceived hatred and can be experienced externally and internally. A lot of young people experience internalised homophobia. But it is often hatred or fear experienced in their networks or externally. I am not being terribly articulate here, because I should be referring to a definition. Would anyone like to add to that?

Ms LAMBERT: I would add that it includes verbal and physical abuse and exclusion and isolation, which is when someone might be shunned from peer groups or not included in various activities. Homophobia is not only physical and verbal abuse; it can also include more insidious and underlying behaviours. Comments can be made that we often take as flippant, such as "You're so gay", but that can have an accumulative affect that does contribute to what we call minority stress. The messaging can say, "You are actually not okay; you are different."

Ms DAVIES: That is often internalised by young people, which can lead to self-harm and suicide ideation and attempts.

The Hon. GREG DONNELLY: What is the definition of transphobia?

Ms LAMBERT: It is very similar, except it is directed towards people with diverse gender identity. With transgender people, it can include purposefully misgendering people and not acknowledging how they live in the world. It can include put downs and exclusionary matters. But there are high rates of physical and verbal abuse—certainly much higher than other populations.

Mr HUMPHREYS: It is also worth noting that sometimes people have good intentions but can say things that are really harmful because it is part of the dominant culture of our society. People do not know a lot about transgender and gender diverse people and have strong feelings around gender. They can unintentionally communicate that, which can have a negative impact that leaves people feeling unsafe and unwelcome.

The Hon. GREG DONNELLY: Thank you for bringing some clarity to that issue. On page 3 of the AIDS Council of New South Wales [ACON] submission to this inquiry it states:

> LGBTI youth are a significant population. Research from the Australian Research Centre for Sex, Health and Society has found that 16.8% of secondary school students in Australia report that they are attracted to people of the same sex as them or to both sexes.

I have looked at the cited report, the "National Survey of Australian Secondary Students and Sexual Health 2013". The cited data comes from the table on page 23 of the report. There is an incorrect reference—the submission refers to table 5.14, but it is table 4.3. The table on students' sexual attraction has sections for male, female and total, and is broken into four categories of attraction: "only to people of the opposite sex", 78.8 per cent; "people of both sexes", 11.2 per cent; "only to people of my own sex", 5.6 per cent; and "not sure", 4.4 per cent. I gather the 16.8 per cent referred to in the submission added together the people who identified as being attracted to both sexes and the people who identified as being attracted only to people of their own sex. Young people attracted only to people of their own sex made up 5.6 per cent and people attracted to both sexes made up 11.2 per cent. Is the figure referring to bisexuality stable over time? Do the students remain bisexual for the course of their lives, or is that 11.2 per cent only for that point in time?

Ms LAMBERT: I believe the study is surveying people at a point in time. When we talk about sexual identity we are talking about identity behaviours, and they can certainly change over time. We are seeing an increase in the number of younger people identifying as LGBTI or having a diverse sexual orientation. The population is increasing over time. But yes, this is within a point of time.

The Hon. GREG DONNELLY: The percentage of young people who are bisexual is 11.2 per cent. That is a large percentage, which creates the 16.8 per cent. I am trying to understand the size of the issue. Does the 11.2 per cent change over time or is it something that tends to stay stable?

Ms LAMBERT: It depends on the ways in which it gets acted out on for people. Certainly in this young, formative stage when there is attraction to both genders, it is the messaging that will dictate what happens over the course of time and whether that person goes on to identify as LGBTI and pursue that identity. If they do not have support it is more likely to be internalised as being negative and unwanted. More and more

we are seeing that young people see themselves as being on a spectrum and having more diverse sexuality, rather than putting themselves into boxes. We are seeing people who are more fluid in their sexual orientation.

Ms DAVIES: Most of the studies that are funded are cross-sectional studies, rather than longitudinal cohort studies over time. We cannot answer the question of the stability of some of these identities, but I agree with Ms Lambert that young people do need that support. I also want to make a distinction between sexual attraction and sexual identity. Some people who are sexually attracted to both genders or sexes do not necessarily identify as bisexual—they might identify as heterosexual, depending on what context they are in. Earlier, we talked about homophobia and transphobia, and it very much depends on what context and environment the young person is in as to whether they will identify in a particular way. That question is interesting because it is about sexual attraction, rather than sexual identity.

The Hon. GREG DONNELLY: Do the well-known services, such as Lifeline and Kids Helpline, have specific training and guidance for their staff who may interact with young LGBTI people, whether via telephone or social media, to enable them to give them the best guidance possible? Those two organisations are well known across the broader community and I presume a young LGBTI person would equally perhaps have heard of Kids Helpline or Lifeline. It is important for us to understand that organisations which are well known and have some serious skin in the game, so to speak, have some capacity to deal with what other contacts invariably come their way.

Mr HUMPHREYS: To be honest, I have not dealt with those organisations particularly, but I know that our QLife national clinical director has been on steering committees, meetings and working groups with those organisations, and has worked on building relationships with them. My understanding is that one of the things that they are seeking is some specific support in being more inclusive and respectful for LGBTI clients right across the age groups, but particularly young people because that has that specific need. I would only be assuming to say that it is likely that they do not—or at least only have a quite basic introduction to that, like many mainstream services.

Ms LAMBERT: Certainly the AIDS Council of New South Wales [ACON] has been approached at points in time when they have had new recruits to do in-services. I would not say that it is necessarily as a comprehensive training program. Again, it speaks to the need with mainstream services to be more than training, that it is actually built into policies, procedures and the practices of clinicians and those working within those organisations—so the support structures that underpin it, and help transfer that learning that happens in training into practice.

The Hon. GREG DONNELLY: Approximately 50,000 contacts were made over the 2016-17 period. As a subset of that, approximately 20 individuals were classified as likely to do something quite serious. Do you know what the numbers are for the past five years for those people who are perhaps flagging an intention?

Mr HUMPHREYS: Not for the whole service. We would need to get that from the clinical director at the National LGBTI Health Alliance.

The Hon. GREG DONNELLY: Could you take that on notice, going back for the past five years?

Ms DAVIES: Yes.

The Hon. WES FANG: In the ACON submission you comment there is a high rate of suicide inside the LGBTI community and that requires a unique response. Are you aware of any programs in your campaigns that have been trialled in other jurisdictions and can you comment on those?

Ms LAMBERT: I would say that certainly with LGBTI mental health there is not a large investment in this space. Often they are small community organisations who are doing the best they can with limited resources. I would point to LifeSpan framework which has two trial sites, one in North Melbourne and one in Brisbane, which is LGBTI specific. The hope there is we will get some good evidence of need and what approaches work within those spaces. The ACON has been funded by the Ministry of Health in the LifeSpan initiative to deliver two of the nine pillars of LifeSpan within Sydney, south-east Sydney and St Vincent's network areas—being where our communities are concentrated.

The two pillars that have been funded are GP training and after-care support to provide a referral pathway. Again, it is a small site. We very much see that whenever we are working with our communities it is twofold: one meeting the needs of our communities, and the second building the evidence to actually support evidence-based approaches going forward. I would say that there is still a lot of work to be done in this space. Those, I guess, trial sites are exciting and it has been written into LifeSpan that LGBTI are a proactive population. I guess what it shows is a good example of where you have something written into policy but it is

actually linked to action. Often things are mentioned as a priority population but it does not actually go into how that is going to be addressed.

Ms JODIE HARRISON: There are a number of other LifeSpan sites, but only two specifically for LGBTI people?

Ms LAMBERT: Two that are specific for LGBTI. Most LifeSpan sites are geographically based and our communities are not geographically based—they are spread out. Those are two sites which are happening in high-prevalence populations, specifically LGBTI. With all the others we are working with Black Dog Institute and Suicide Prevention Australia to make sure that any interventions have some LGBTI inclusivity built within. It is very much into the framework but there are two sites that are specific for LGBTI, then our small around GP training and after-care support in Sydney.

The Hon. GREG DONNELLY: Thank you for your detailed submissions. There are 27 recommendations in the 2010 submission. Recommendation 14 concerns the increasing number of young people seeking to take up hormone therapy, and then, it appropriates, surgery. Are there studies being done of those individuals to see how they are going post the hormone therapy and the surgery? These are serious issues that these young people are contemplating and facing as they wonder about identity. Hormone therapy and surgery are significant steps. Surely these people must be tracked beyond the first and second stage so that an assessment can be made about whether or not—if I can use this phrase—what is being delivered is ultimately meeting expectation.

Ms DAVIES: I am happy to respond to that. I have been in contact recently with the gender service at the Royal Children's Hospital in Melbourne, and they do indeed track how young people are going. They collect data about the service that they are offering and how young people are going. I cannot remember the exact name of the study; it could be Trans20—I will have to get back to you about the exact name of that study. But they are collecting data about the experience for service users, including young people and their parents, and they are collecting data over time. Indeed, there is a publication coming out soon with regard to experiences of the service and the decrease in distress from those, both adolescents 12 and up and their parents after they have accessed a publicly funded, multidisciplinary gender service—so having a massive impact on young people's mental health there.

The Hon. GREG DONNELLY: It is early days, because surely the judgement of this is over time.

Ms DAVIES: Indeed, that is why we are doing the data collection and that is why they have started that data collection. I could not tell you what year but I could get back to you about that.

The Hon. GREG DONNELLY: If you could take that on notice—if there is a particular report?

Ms DAVIES: Sure.

The ACTING CHAIR: Thank you very much for coming in today, the submission you have made and the evidence you have given. In line with the observation just made to Mr Donnelly, I take it you are happy to answer any further questions the Committee may ask you on notice?

Ms DAVIES: Absolutely.

(The witnesses withdrew)

JASON ANDREW TRETHOWAN, Chief Executive Officer, headspace, sworn and examined

KRISTEN DOUGLAS, National Manager, headspace School Support, headspace, affirmed and examined

NARELLE LOUISE CORLESS, NSW Manager, Statewide Services, headspace, sworn and examined

The ACTING CHAIR: Thank you for appearing before the Committee and for the submission you have made. Please confirm that you have received the information pack for witnesses appearing at committee hearings.

Mr TRETHOWAN: Yes.

Ms DOUGLAS: Yes.

Ms CORLESS: Yes.

The ACTING CHAIR: Do you wish to make an opening statement in support of your submission?

Mr TRETHOWAN: Headspace, the National Youth Mental Health Foundation, operates across Australia in a number of ways. It has been running in New South Wales since 2007. Across Australia there are now 101—soon to be 110—headspace centres, 36 of which are based in New South Wales. As communities typically understand it, a headspace centre is a youth-friendly environment for young people to seek help, particularly early on, in dealing with anxiety, depression, family-related issues, physical health issues, drug and alcohol issues, and general health issues.

Young people seek help through headspace where mental health is becoming a barrier in their day-to-day lives, such as staying connected to school, to work or to study and also where they are experiencing relationship issues with key people in their lives such as family or friends. Headspace programs are complemented by an online mechanism. From 9.00 a.m. until 1.00 a.m. seven days a week young people and their family and friends can make contact. We have 80 to 90 mental health clinicians working across the week engaging with young people and talking about mental health issues. Interestingly, 50 per cent of those young people will raise their mental health issues for the first time—that is, they have never before spoken to anyone about their issues in a clinical setting. We know that young people are online and are seeking help online.

That is backed up by headspace School Support, which has been acknowledged by the NSW Department of Education as providing support for school communities that are grieving the loss of a significant school member, such as a student, a teacher or another staff member. Headspace also provides a range of stigma-reduction programs. It is a positive and recognised brand for young people. For the past 11 years, we have been breaking down the stigma associated with mental health. Too many past generations of young Australians have not sought help when they needed it. Unfortunately, if they do not seek help their mental health can deteriorate and that can have a significant impact on their lives. Of course, there are tragic consequences for far too many young people.

Headspace promotes a positive, friendly and welcoming environment in which young people can seek help by accessing various mechanisms and talking with family, friends, teachers, and clinicians. There are priority groups of young people such as those from an Indigenous background and the LGBTI community. We are now reaching out to young Australians living in rural and remote areas, where face-to-face services are limited.

Ms DOUGLAS: I welcome the opportunity to talk about this critical topic. Headspace has been working in this field for a number of years. In addition to lodging our submission, headspace is contributing to a much larger national and contextual conversation about all-age suicides. However, a focus on youth and child suicide reform involves a vastly different approach for all age groups and will require different intervention to reduce and to prevent suicide. What it takes to prevent the death of a 14-year-old might be vastly different from what it takes to prevent the death of a 40-year-old.

Earlier age and stage of suicide risk is evident and over the past decade things have changed significantly for schools and school systems with regard to earlier suicidal ideation, thoughts, feelings and risks. They are emerging earlier and often we are now talking about risk in primary schools as well as in secondary and high schools. Obviously acute distress for young people includes things like bullying and cyberbullying. However, other major stressors also contribute to this space; often it is not one indicator or one risk factor. We qualify the need for continuing prevention efforts and building the mental health capacity of parents, teachers and young people, and also the gatekeepers and frontline service workers.

There is a critical space for resourcing, research and action in assertive after care. Our colleagues from the Black Dog Institute may have talked about assertive after care. We know that one of the most obvious predictors and indicators of someone suiciding is a suicide attempt. I do not think we are doing enough with young people with regard to attempted suicide. It is very difficult to manage the cohort of young people who attempt suicide because their understanding or developmental knowledge of what they were trying to do, their behaviour or their intent often is a very grey space. Young people may attempt suicide on the weekend but not end up in an emergency department; they may not have any physical or medical needs. However, they show up to school on Monday and the school may have no knowledge of that attempt. That is a critical space.

In 2012, headspace took up a Commonwealth-funded program aimed at suicide postvention, which is a relatively new term for schools. Schools often had been exposed to suicide prevention activities, mental health and wellbeing and broader activities but suicide postvention was something completely different. It involved working with schools and school systems to respond to, to recover from and possibly to plan for a death. The aim of postvention was to reduce the impact, to minimise the ripple effect, to look after the ongoing and longer-term mental effects on the kids left in the school community, and to reduce the recovery window to get them back to wellbeing.

We have supported a huge range of school communities across the country since 2012 and have responded to over 1,300 suicides—primary schools and high schools predominantly. Headspace has worked with the education systems and sectors across every State and Territory and has a particularly healthy and positive relationship with the New South Wales Department of Education, and the Catholic and independent sectors. They have done some commendable work in policy development, program development and workforce capability and capacity building. We continue to work with them in the field across New South Wales schools.

Sadly, many of the school communities—New South Wales included—not only experience one suicide but two, three and sometimes four subsequent suicides. Our areas of pointed risk over the last couple of years have included Hunter and New England, Central Coast—well known is the area of ▮▮▮▮▮▮▮▮ Clarence Valley and across to areas such as the Riverina and more broadly. In the rise of suicide exposure in our communities, which leads on to suicide contagion, it is very difficult to identify why exposure is increasing, but the internet may be a significant cause. There are limitations of data for suicide, as I said, around suicide attempt, but also the sharing of data.

I want to acknowledge the gender difference between youth and all-age suicide that obviously boys and men are over-represented. I also pose a commentary around the fact that perhaps the mental health system is biased towards women and the vulnerability and help-seeking behaviours of women because counselling and other services require you to be vulnerable, cry, seek counselling—all things that behaviourally are maybe closer to women and not necessarily men. Method is also a critical issue that we have been watching for the last couple of years. Young men were the more predominant cohort, but young women have increased in suicide data. My sense is that perhaps this is because they are choosing more lethal means and methods such as hanging and jumping—things we were not seeing 10 years ago.

Closer analysis of data in partnership with the New South Wales Coroner perhaps will lead us to new light. We have done some similar projects in Victoria which showed some points of interest around the 820 young people whose deaths we looked into with the Victorian Coroner. I want to acknowledge the impact and the effect on the frontline staff. Some of our staff are sitting behind us. I welcome the microscopic approach that the panel is going to be using. There are lots of opportunities for us to make a difference.

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The ACTING CHAIR: Ms Corless, I take it you embrace all that Ms Douglas has said?

Ms CORLESS: I embrace everything—yes.

The ACTING CHAIR: What do we need to do to reduce males attempting suicide?

Mr TRETHOWAN: I might start. A factor in suicide and males is, first of all, seeking help. I take the room back to what is getting in the way of a young man or a boy actually seeking help. In our work a lot of it comes back to stereotypes of males in generations gone by where boys were told to move on, suck it up, "You'll be right," and there was really not a safe place to express feelings, sadness, loneliness or helplessness. A

follow-on effect we know about from previous studies is that 13 per cent of young men who needed to seek help were actually seeking help—that was a study in 2007.

Whilst we know that more young men are prepared to seek help these days, we are really thrilled with the efforts of schools to promote mental health as an issue that is the same as physical health, but we know we still have a long way to go with boys and young men seeking help. I can only talk on that basis in relation to its flow-on effects. If you are suffering in silence, if there are biological, psychological or other environmental factors, if there are multiple things occurring in a young man's life at any given time, it often highlights the increased risk relating to suicide and also for untreated severe mental health issues.

Ms CORLESS: I have heard a lot of comments today about relationships. I would like to connect that with this question you just asked. From our statistics and from working with school communities that have experienced a death by suicide, there is a lot of comment about the young man who had had a relationship breakup as a tipping point or a stress point for that young person prior to an attempt or a suicide death. One of the things we have been working really hard at with the Department of Education across all sectors is looking at how we talk with young men and bolster their mental health literacy on coping with relationship stress and who they can access.

The ACTING CHAIR: Tell me about that. How are you developing programs or processes for that specific issue which you have identified as potentially one of the triggers?

Ms CORLESS: It is about broadening support systems within schools, so not just going straight to the school counsellor, who deals with very clinical, specialist ends of needs in school communities. We have run quite a lot of professional learning with—a whole school one—executives, principals and sports coaches. We have partnered with the National Rugby League [NRL] to do postvention planning through football clubs in regional communities. We have broadened across communities, building capacity across communities, particularly with middle-aged and older men—often one on one—or supporting younger men. The message is how they can talk about accessing help or talking to them about how they can do something for themselves, which might be mindfulness, or a whole range of things that young men and young women can do for themselves before they access other help.

The Hon. GREG DONNELLY: How is "relationship breakdown" defined? People have multiple relationships. In the context of what you are describing, what is a relationship breakdown?

Ms CORLESS: In a high school we are really looking at someone who has had their first love. You are probably looking at a 14-year-old or 15-year-old who has had what they would consider their first serious relationship. That might be a two-week relationship or a longer term relationship, but for them it was their first significant one. What we know about young men is that they really invest in that and that is probably the first time that they start showing and opening up their feelings and their connection with someone else at a deeper level. So when that relationship ends it becomes a very stressful time for them and a big point of disconnection.

The ACTING CHAIR: Ms Douglas, you made some observations about the connection between social media and self-harm. Would you like to elaborate on that? We have heard evidence today which potentially says that the link between social media and the so-called bullying in social media is overplayed. Is that your experience?

Ms DOUGLAS: Demonising social media is a dangerous thing. This is where young people are at. We have been trying to use social media in a helpful way for young people to help seek. An example of that was we worked with Facebook during the Grafton situation. During school holidays we knew it was very hard to access young people because school was not open so we did some geotargeted mapping so that, on their news feed, gentle and subtle ads about mental health services were coming up. The analytics behind that showed that 10,000 people viewed those ads in 48-hour periods.

There are far-reaching possibilities for social media. However, on the flipside of that, it is also a huge and problematic situation for schools to manage and contain information, and to manage and contain distress. When it is overwhelmingly distressing on a young person, it is very difficult to access and support that young person. We have a partnership with the Office of the eSafety Commissioner and will be working with them in an ongoing way about how we can look at cyberbullying and bullying generally. However, social media is a very complex beast. It is absolutely adding to the risk of young people in 2018.

The ACTING CHAIR: This question might be a bit difficult. Are you able to identify young people who are more at risk in relation to social media usage than others?

Ms DOUGLAS: Maybe previously it was the older age groups. But now we see that young people have access to social media in primary schools and access to iPhones. I think that all kids generally are at the

same potential risk. It is difficult for parents to monitor the level of activity on social media. However, I do not think the solution is to shut kids out from social media, because often that is the place that they connect to seek help, as Mr Trethowan said.

The ACTING CHAIR: Are young people accessing headspace through social media?

Ms DOUGLAS: Absolutely. We have Facebook and Twitter accounts. We connect with young people through WebChat through eheadspace. In fact, it is their preferred medium.

The ACTING CHAIR: I suppose that is a 24/7 service?

Mr TRETHOWAN: The service is run seven days a week, 9.00 a.m. to 1.00 a.m. Australian Eastern Standard Time.

The ACTING CHAIR: What is the peak period?

Mr TRETHOWAN: It is similar to the emergency departments of hospitals. After 5 o'clock through to about 10 o'clock is the peak. To give you an idea, we have about 15 clinicians on at night and probably four to five during the day. So we are reaching young people, nine to five, who are accessing health services necessarily. We see lots of young people accessing us in the evening in their own bedrooms or wherever they may be.

The ACTING CHAIR: In respect of the number of people who are accessing your site, are you able to identify those who are at risk of self-harm?

Mr TRETHOWAN: They will identify as at risk of self-harm. Ninety-five per cent of exchanges with young people through our eheadspace platform are via our WebChat service—basically text messaging between each other and the clinician. Where we have significant cause for concern for a young person we will immediately act on it—using 000, obviously, if we have identified where they are. They are pretty complex scenarios. I want to add a little more about the online environment with respect to young people and suicide. There has been, in more recent months, a lot of focus on cyberbullying and its link to suicide. Headspace does not believe that cyberbullying alone leads to suicide. I think we all recognise, through this hearing, that suicide is incredibly complex. It is multifaceted. There is never one issue. Ms Douglas' point about social media is true. That is where young people are; we do not want to shut it down. We want to have an environment where it can be used more for good than for evil. Unfortunately, cyberbullying is the new entrant into the market, where young people can be bullied outside of the schoolyard, but it is not necessarily a single factor that leads to suicide.

The Hon. WES FANG: You outlined postvention in the submission. Can you expand on that a little? What does it include? How is the program that we are rolling out in schools going at the moment? What do you see that leading to in the future?

Ms DOUGLAS: Definitively, "postvention" is a term that has been used nationally and internationally—probably more around critical incident response. Suicide postvention obviously is more targeted at the suicide impact and response. For the last five years our vision of our scope has been to respond, recover and help schools prepare in terms of suicide. We have worked with education systems across the country. Some of those have very comprehensive policies in terms of response, recovery and planning. The difference with suicide postvention is that it is one of the only critical incidents that may lead to further risk and harm. It is different from car crashes, cancers and the like. Suicide postvention for us has been a very dynamic learning space. There is not a huge amount of international data to show the longer-term recovery of communities.

We have serviced a huge range of different communities in the last five years. Interestingly, while New South Wales has the biggest population we do not have the highest number of responses. There is a higher number of deaths in Victoria and Queensland, which I would say is probably down to exposure and contagion in communities. The program has developed a very deep, positive footprint in schools. People have engaged with it. Five or 10 years ago schools were very paralysed by the fear of talking about suicide. We have worked with school systems, particularly in New South Wales, to educate school leaders about the helpful ways to work with students and families around suicide, and the harmful ways.

We have developed some world-class resources, such as the headspace toolkit, which is easy to pick up and easy to use for schools leaders. We have fact sheets and practical knowledge of what may create further harm and what may create further risk. Our toolkit looks at what to do in the first day, the first week, the first month and the first year. We essentially keep a relationship with the school for two years. We see risk spikes in the population three, six and 12 months later. It may come in the form of self-harm and self-injury, emergent

mental illness or suicide attempts in that same cohort of kids. When you are talking about a school of 1,000 kids, the ripple effect a second and third time around is huge.

The Hon. WES FANG: You were just saying that the contagion effects in Victoria and Queensland seemed to be higher? Is there something that we are doing right here, or is it that because we are getting more involved in the postvention space we have not seen the contagion effect take hold here?

Ms DOUGLAS: Policy-wise and structurally-wise, New South Wales has a very comprehensive platform of services. That is a contributing factor. New South Wales has had limited child and youth suicide compared to other States leading up to this year, which means that the exposure and contagion may have been less. I would say that the mental health literacy and help-seeking approaches by the Department of Education has been a huge contributing factor. There are a lot of things going right in New South Wales, and we now apply that knowledge to other States and Territories.

The ACTING CHAIR: One of the issues is the way we talk about suicide. There are some media people who never talk about it and never identify it. What is your view in relation to how we should talk about suicide?

Ms DOUGLAS: It is a very difficult space, and it is an argument in the suicide sector. The more we talk about it publicly and acknowledge the challenge of child and youth suicide, perhaps the more we will draw the attention of vulnerable young people towards that story. That is why we have such a reaction to things like *12 Reasons Why*, the way Dolly Everett's story is reported, and a whole range of other media stories. We are very careful to make sure that our messaging is around help-seeking; directing kids, when they are feeling vulnerable and distressed, to mental health services; and not talking about the method and detail of one particular suicide. It is very difficult, because young people are often drawn towards the facts, and they will find connection in that. That is when you see exposure and contagion.

The ACTING CHAIR: At the same time though do you take a view in relation to the extent to which young people ought to talk about it?

Ms DOUGLAS: We are very strong in gatekeeper training. We give skills to schools and work with education systems about the gatekeeper training that you were referring to before. The gatekeeper training is about having the ability to ask the two or three questions you need to of a young person when you notice that they are in distress or at risk. Those two or three questions include: Have you had thoughts of hurting yourself or killing yourself? If so, do you have a method or a plan? Do you have a timeline to your plan? Those are three very difficult questions to ask a young person. That is why we have training behind those three questions. The ability and the necessity to ask those three questions is becoming more prominent because young people are far more likely to disclose that risk—we hear it on e-headspace, Kids Helpline and Lifeline—and they tell you the truth: They are going to hurt themselves, they do have a plan and they do have a timeline. At least then you can act and intervene.

Ms JODIE HARRISON: Headspace in schools does some really wonderful work in postvention. Have you been involved in postventions as a result of a young person not involved in the school system? Do you have any comments on the role of FACS and its knowledge of children and young people who are in their radar in their role as gatekeepers?

Ms DOUGLAS: Any young person who has experienced trauma or acute distress in the first 10 to 15 years will be at a higher risk rating than a young person who has been connected and has lots of protective factors wrapped around them. Outside of the education system, it is more difficult to have responses. Hence why I think the coronial process and looking at that data will look at comprehensively all of the data while we only have access potentially to notification of kids who are either in a school or have just recently left a school. The other concerning cohort is the 18-, 19- and 20-year–olds who have just left school, and possibly the containment of school, and have gone on to TAFE and university and become very acutely at risk as well. Our partnerships across Juvenile Justice and human services across all States and Territories need to strengthen. It is a very complex situation when it comes to confidentiality and individual cases.

Mr TRETHOWAN: I think where we would see the next priority beyond the school system is actually in university and TAFEs. We partnered with the student union for universities back in 2016 and released a report early 2017 which highlighted that 35.4 per cent of respondents had thoughts of self-harm or suicide, which is significantly higher than, obviously, other parts of the population. Transitions in life—whether it be from primary school to secondary school or, in the case of suicide, more so from secondary school to tertiary studies or to the real world when you have to go out and get your first job or move out of home—a whole range of factors are obviously leading young people to question around their mental health and wellbeing. We know that through research that others, like Orygen, have done in Australia and we know from engagement

with the universities and the institutions themselves around the risk of suicide and self-harm, and it is something at the moment that we are not doing well enough. I absolutely pay credit to the work that headspace has done in the past and in the present in relation to postvention work in schools, but there is a big gap in our university and TAFE sector.

Ms CORLESS: I would just make one more comment. We have been working with distance education staff that are managing at-risk young people who are disengaged from schools and also supporting School-Link and other mental health services that work with Juvenile Justice education settings.

Ms JODIE HARRISON: Do you have any postvention programs for universities? Have you ever been involved in something like that?

Ms DOUGLAS: We would like to develop and translate what we have into the TAFE and university space.

Ms JODIE HARRISON: But it is early days.

The Hon. GREG DONNELLY: Ms Douglas, in your comments at the start of this session you mentioned some limitations around sharing data. Would you please elucidate? What are your experiences of limitations around the sharing of data?

Ms DOUGLAS: We are working in a space where a number of organisations hold their own internal data. There are limitations about sharing data. I do not think it is through lack of goodwill; I think it is a limitation of understanding the risk of confidentiality. I also think that across every State and Territory border, data, contextually and definitively, looks different. So having a broader national approach to sharing data is very difficult. I know in talking with our colleagues at Suicide Prevention Australia, who have consistently pushed for a child and youth death registry but also a broader national suicide registry, it is a difficult thing because coronial processes are vastly different in every State and Territory. Their recording of suicide—single-vehicle accident may not actually be recorded as such. As to the actual reality of the data, my sense is that there is more suicide than is recorded. The other really big issue is the data around suicide attempt and our ability to record that. However, we are working with the Primary Health Networks [PHNs]. We have shared data with Black Dog and we would happily share data with other services and systems if it meant that there was some level of improvement.

The ACTING CHAIR: What would you recommend that emergency departments do in terms of retaining data or developing a data system that is usable by organisations such as yours which can lead to better outcomes?

Mr TRETHOWAN: Yes, I think this comes to system issues, full stop, in the health system, where data resides in one silo and is not shared enough with others. In the emergency departments, New South Wales will have a whole range of data capture needs for their own purposes and State government purposes. The key issue is around system integration, meaning that if a young person—say, a headspace client—presents to an emergency department with self-harm, what does headspace know about that young person who has presented? It is patchy at best in terms of the communication between one part of the health system and another. And obviously a big indicator is someone who has attempted suicide, and obviously that is why after care is so important so that there are follow-up mechanisms in place.

We should not have to wait for trials to start that test the following up of a young person or an adult who has gone through a process of self-harming in order to say we need the services. The health system is so full of services caring for people at the pointy end of the system. We have highly vulnerable individuals—lonely, helpless individuals—presenting to emergency departments with inadequate, insufficient follow-up care and, dare I say, a complete breakdown of the mental health system prior to the pointy end of specialist mental health services, where terrific care is provided today in New South Wales. Terrific care is provided in a primary care setting. But there is a big gap in the middle of the mental health system, and that is to follow up with those people who have obviously reached a very severe and late stage of distress or mental illness and actually provide supports for those people and prevent unnecessary—well, of course, all suicides are completely unnecessary.

The ACTING CHAIR: I am pleased I asked that question.

The Hon. GREG DONNELLY: One of our earlier witnesses today, through their submission, indicated they have collected data down to the age of five. I struggle to comprehend the nature of understanding that, for example, a seven-year-old would bring to thoughts and verbalisation around wanting to end their life. We know the executive part of the human brain does not reach full maturity until the mid-20s or thereabouts. So I struggle to understand that a young person of six or seven years of age could understand the notion of suicide.

Given your broad experience, could you talk about episodes of particularly young people contemplating or talking about or even going through with suicide. Is that increasing? Is it something we are just starting to appreciate is a very real issue? I would appreciate your thoughts.

Ms DOUGLAS: Suicide risk in primary schools is certainly something that has become of great concern with us, and we are working with departments of education. ████████████████████████████ ████████████████████ A lot of people would say, "How is it possible that that young person even had knowledge of how to carry out that behaviour?" But suicidal and emergent risk, I think, is increasing at the same level that distress is increasing for younger people. The Australian Bureau of Statistics [ABS] changed their definitions of suicide in the last two years. Now, if you google "suicide in Australia", you will come up with a new term "death by intentional self-harm".

The reason was the ABS statistics used to show ages 15 through to about 75. They added two new categories: 0 to 14 because of the number of young people dying by suicide, and 80 to 85 or 90 years because of older people dying by suicide. The risk that we see is because young people are impulsive. They have high and acute distress, and perhaps exposure to information and knowledge on the internet on how to carry out that act is more available. But it is absolutely apparent to us that primary schools are experiencing suicidal ideation, thoughts and feelings down to grades 1, 2, 3 and 4.

The Hon. GREG DONNELLY: Your answer is truly shocking, that that is a reality in Australia today. I do not mean to sound trite but it is a shocking statement you have made of the reality.

The ACTING CHAIR: Have you been able to identify cases where this has happened? Have you had experience?

Ms DOUGLAS: Yes.

The ACTING CHAIR: What are the triggers for a five-year-old to have ideation about self-harm?

Ms DOUGLAS: ██ ██ ██████ I think the high level of suicide that you have in your community, school, or sporting club means that the more exposed young people are, the more they have learned knowledge of this behaviour. That is why we are very cautious about how we talk and act and work with schools around this area.

The Hon. GREG DONNELLY: It is tragic—"tragic" does not even come close to describing it. With respect to the numbers of attempted suicides, I gather that is something that is very hard to grasp and quantify, given that a number of young people, in particular, for the purpose of this inquiry would not share that information or may not be prepared to share that information. But from your work as an organisation over a period, if we see a figure of a number of suicides in, say, a 12-month period among a youth cohort, can we expect that there was, by a factor of X or Y or Z, attempts that, thank goodness, were not successful? Alternatively, is it not as scientific as that because we just do not know?

Ms DOUGLAS: In the last two years Suicide Prevention Australia, beyondblue, headspace, and a whole range of others have mulled around various factors and it has floated around that 30 to 40 attempts for every suicide. That is for children and young people. Perhaps in the older age group it is around the 150. I think Jo Robinson, who presented, may also have posed some thoughts around that as well.

The Hon. GREG DONNELLY: There is one final question from me. It is a bit provocative, but I bowled it up to witnesses earlier today. Obviously some organisations are doing outstanding work—Lifeline, headspace and Black Dog—but to the extent that there may be some overlap in the work that is being done, or even repetition with the very same programs being introduced and rolled out, from the State's point of view is there a case for getting the most value of the funding that comes in to support this most important work through some hard-headed consideration of rationalising to ensure there is specialisation taking place by organisations that have a comparative advantage and have shown that?

In other words, is there value in saying, "Perhaps you do more work in this area, but perhaps pull back from here"? I could be wrong, but I just fear that if a whole lot of organisations are out there doing things, there is a capacity in any circumstance to have overlap. The duplication of services obviously makes no sense, if in fact we have to become quite rational about the funding we can provide overall. Would you care to comment on that?

Mr TRETHOWAN: I think your point is really well made.

The Hon. GREG DONNELLY: I am not pointing the finger at anyone; I am just trying to understand.

Mr TRETHOWAN: No, I know. But if you look at the organisations that are providing the services that you have outlined, they are not-for-profit companies that are often competing for government grants or other philanthropic funds to run services that they genuinely want to do more of and continue to improve. I think there is a really strong appetite among leaders in the mental health system—or the sector, I should say—whereby we want to identify each other's strengths. We do not believe in wanting to overlap or compete.

However, governments have instruments as in who they fund, what they fund for, and what expertise they believe they need based on feedback that is provided to them genuinely by the sector. I think there is a really strong appetite—I know—among the top eight or nine mental health organisations in Australia to work more collaboratively together. That has been evidenced in recent times by those organisations getting together and having that exact discussion.

Ms DOUGLAS: May I add two comments? Of all the suicide trial sites, not many of them are specifically working just with child and youth. As I said in the very beginning of my opening statement, child and youth interventions to reduce and prevent suicide may require vastly different approaches to all age suicides. That is the first thing. The second comment is around the fact that while we are working collectively as a group—eheadspace, Kids Helpline, Lifeline, headspace centres as well as all the intervention and implementation services—we are not dealing with the same cohorts of people.

There is enough to keep us all at demand Monday to Friday. It is easy to say pull away from duplication and do that sort of stuff, but for whatever reason some kids are attracted to the Kids Helpline, some people move and gravitate towards Lifeline, some come to our eheadspace, some come to centres, and some come to QLife. But ask all those services and they are at capacity. It might be a bit of amalgamation but, for whatever reason, different brands attract different people. That is a comment.

The Hon. GREG DONNELLY: Thank you.

The ACTING CHAIR: Thank you very much for coming. Ms Douglas, we have heard from you before and I am always very grateful when you appear. You speak so very clearly about those issues and I am very grateful for the input that you have given us. As usual, if we have additional questions are you happy to answer those questions if we put them to you in writing?

Ms DOUGLAS: Yes.

The ACTING CHAIR: Thank you very much for attending today. The Committee will resume at 2.30 p.m.

(The witnesses withdrew)

(Luncheon adjournment)

PAMELA SWINFIELD, Director Practice Support, Office of the Senior Practitioner, NSW Department of Family and Community Services, affirmed and examined

The ACTING CHAIR: I welcome Ms Pam Swinfield from the NSW Department of Family and Community Services. Do you wish to make an opening statement?

Ms SWINFIELD: I would welcome that. Thank you. I would like to start by acknowledging the traditional custodians of the land on which we meet today, the Gadigal people of the Eora nation, and to pay my heartfelt respects to elders past, present and future and to any Aboriginal colleagues or people present today. I thank the Committee for the opportunity and the invitation to appear before this inquiry into the prevention of youth suicide in New South Wales. It is extremely tragic to see the deaths of young people due to suicide. As an agency, Family and Community Services [FACS] recognises that adolescents who come to our attention and are known to FACS can be especially vulnerable, so we are committed to working with our partner agencies to better support them.

Family and Community Services works with children, adults, families and communities to improve lives and help people realise their full potential. FACS does not fund or provide services that have a specific focus on suicide prevention. Instead, FACS supports vulnerable children and young people with complex needs who are either in the child protection system or at risk of entering out-of-home care. FACS supports vulnerable children and young people by working with their families to address reported abuse and neglect. Many of the children and young people we work with have experienced significant trauma and often a range of other adverse childhood experiences. Commonly, they have identified mental health needs related to the adversities that they have endured.

Our work in FACS requires effective collaboration and coordination with other government and non-government agencies and local communities, focusing on prevention where possible and providing targeted assistance to those most in need. Children are usually reported to FACS in circumstances where abuse has already been occurring. In this context, prevention for FACS is about working with parents to address risk issues to prevent further abuse and neglect. FACS collaborates with specialist services that address trauma and mental health needs of parents and children and young people. FACS also notes that there is a lack of funded services in rural and regional areas which present particular service challenges.

We know that building relationships of trust with parents to help them get the help that they need helps children to stay at home safely. Relationships are also the key to positive outcomes in working with vulnerable young people. High quality training and staff supervision are critical for FACS staff delivering effective services to vulnerable young people and their families. We have received some seed funding to trial an intensive skills and development program in the Hunter and New England districts which is showing some promise in relation to developing a particular skill set in our staff.

Reviewing child deaths is a critical component of the work undertaken by FACS to deliver a better child protection system. Even when deaths are due to natural causes, child death reviews provide a window into FACS' work with children and their families and rich learning opportunities for practitioners both within the agency and externally. Reviewing our practice with a family after a child death and reporting annually also delivers on the Government's commitment to hold ourselves publicly accountable for how we responded to families prior to a child's death. The other important purpose of this work is to inform the public about the complexities of child protection practice and the very real disadvantage that many New South Wales families face.

In summary, young people known to FACS are more vulnerable to suicide than the general population. FACS works with families to support parents to make changes to reduce risks. Often these risks are related to poverty, domestic violence, mental health issues and substance misuse. We are trying to help parents to make those changes so that ideally children can remain safely at home. When children cannot remain safely at home, FACS is working to ensure physical and emotional permanence for children in out-of-home care and to improve the currently less than ideal outcomes for children who are in out-of-home care. As part of recent reforms, FACS is also currently working across government to identify opportunities for earlier intervention with vulnerable people before they are reported to FACS.

The Hon. GREG DONNELLY: In your introductory statement you made reference to the provision of some seed funding for training of FACS staff—did you say it was in the Hunter?

Ms SWINFIELD: Yes.

The Hon. GREG DONNELLY: Setting that aside for the moment, what training do FACS staff have around the issue of youth suicide and the things to look out for and be sensitive towards? What training is currently in place?

Ms SWINFIELD: I think we referred in our submission to a comprehensive practice kit which is on our intranet. That outlines self-harm, suicide and child protection and talks about how to talk with young people about suicide, so it provides guidance around how to identify children at risk as well as how to intervene to try to support young people in that situation. There is also—

The Hon. GREG DONNELLY: Is that training mandated?

Ms SWINFIELD: That is not necessarily mandated; it is more that there is a resource for people should they encounter the issue of young people who are at risk of suicide. The mandated training for case workers is an entry-level course, where people attend and do some online training modules as well.

The Hon. GREG DONNELLY: Does that deal with the issue of youth suicide?

Ms SWINFIELD: I will have to take that as a question on notice. It certainly used to, but I am not currently across the detail of that program because it is being reviewed and rewritten. I will take that on notice.

The Hon. GREG DONNELLY: Take the second part of this question on notice. What is compulsory training for FACS employees? Was the first reference you made a program for those who are interesting in exploring and obtaining resources? Is that the best way to describe it?

Ms SWINFIELD: No. It is more linked to the idea of just-in-time training. The entry-level training certainly used to have modules for working with mental health. Whilst I cannot vouch for what is currently in that training program, we really try not to overload people with front-end training when they come into the organisation; rather, we introduce them to the legislation and to what it means to be a statutory worker with statutory powers. We give them an introduction to the most common risk factors that they are going to encounter in terms of working with parents with domestic violence issues, substance misuse issues and mental health issues.

There is certainly some level of coverage around all of those issues. Then we try to make sure that people have access to specialist information as the need arises so that there is access to that mental health kit. There is also a specific set of guidelines that have been developed by psychological services around suicide and self-harm risk, and how to manage that. There is also access to clinical consultation from the clinical issues unit that specialises in substance issues, mental health and domestic violence. People also have access to senior case workers—casework specialists who can provide guidance and direct them to these resources that are available on line.

The Hon. GREG DONNELLY: Say, for example, a FACS caseworker came across a matter—or a matter was brought before them—where there was, in that person's judgement, some potential for a young person to commit suicide or have some ideation. If those things were raised in some discussion or conversation what would the FACS caseworker do? Would they manage that themselves, or would that be something that would immediately send up a red flag and be passed on to someone with more expertise in the area?

Ms SWINFIELD: With respect to that sort of issue, the caseworker would be trying to engage the young person with appropriate services, because the assessment of suicide risk is a specialist area, as is working with young people to try to address the issues that are leading to that.

The Hon. GREG DONNELLY: What sorts of services would they typically be directing them to?

Ms SWINFIELD: Places like headspace and child and adolescent mental health services, where they are available. There are sometimes waiting lists to get into those services. There are sometimes other services, like adolescent health services and so on, that can assist. Predominantly, we would look at people who are specialists in working with those at risk of suicide.

The Hon. GREG DONNELLY: What about the data that FACS retains on instances of children or young people on FACS's radar who take the tragic step and commit suicide? Is that information recorded?

Ms SWINFIELD: Sorry, I am not quite sure of the question.

The Hon. GREG DONNELLY: Let us assume there is a child or young person in New South Wales, who is known to FACS. The child has had contact with FACS and presumably there is a file open or there is a caseworker aware of a child or young person. On an annual basis, a number of children and young people who are known to FACS commit suicide in New South Wales—is that information recorded somewhere?

Ms SWINFIELD: Yes.

The ACTING CHAIR: It would be recorded by the Child Death Review Team.

Ms SWINFIELD: Absolutely. We have an annual child death report. That is a public annual report around any child who has been reported to Family and Community Services in a period of three years before their death, or a sibling who has been reported to Family and Community Services in the three years before the death. If that child dies, we report on that in this public report.

The ACTING CHAIR: Finally, in terms of those reports, what are the learnings? What does FACS do to enhance and improve its capacity to deal with the issues arising from those annual reports?

Ms SWINFIELD: The annual report is distributed to our staff, and when we have cohort reviews that have significant lessons for our staff we deliver mandatory training around that. For example, the 2014 annual report did a cohort review of children who died in a three-year period—111 young people, teenagers—as a result of a range of causes. I think about 41 of those had been as a result of suicide, and nine of the 41 were Aboriginal. The findings of this cohort review were shared with our staff, and they all attended compulsory training about intervening to support young people. The key findings from this review were about how to work in a way that sustained positive change with young people.

You would be aware that we are working in a space where parents can sometimes be involuntary clients. Likewise, teenagers may not be coming to us, necessarily, asking for help. That is where the relationship-based practice skills that I referred to in my opening statement are very critical. Some of the information that was sent out to people, and that they participated in in their learning forum, was about how to engage young people in conversations when they were presenting with issues around suicide risk and self-harm.

Ms JODIE HARRISON: What might a conversation between a FACS worker an a child who was known to FACS look like? I am talking about a child who was at risk of suicide. How does a worker know that that child is at risk of suicide?

Ms SWINFIELD: It may be that that is from information we have received via a report from a third party, or it might be that we are already working with a family and a child starts to talk about wanting to harm themselves. In terms of the conversation that staff might have with a child, it is very dependent on how the information has come to their attention, and the circumstances of the conversation itself—but certainly wanting to acknowledge any feelings that the child is expressing around some of the adversities they are experiencing, talking about what supports are available for children and young people who are feeling as if they want to hurt themselves, and trying to encourage that young person to contact the right service to get some help. It would be trying to give them some sense of hope around other young people that you may have met who have experienced similar difficulties, and that there is help available. The worker would try to plug them into the help that is available and give them a sense of hope around getting through this.

Ms JODIE HARRISON: One of the terms that has come up in number of submissions relating to the prevention of youth suicide has been the term "gatekeeper." Some of the submissions have made suggestions that FACS staff might be the relevant people to be gatekeepers, and that there is a need for proper training and support for gatekeepers. What is your view on that?

Ms SWINFIELD: I think we certainly are already in that space to some extent. However, I think that there are such pressures on our system because of the range of issues that people present with and certainly the gamut of vulnerabilities that children—very young babies through to older teenagers—present with that it is always going to be impossible to ensure that we are able to meet the needs that the demand presents. The system is currently not able to get to all of the reports that we receive. The department has been working very hard to increase the number of face-to-face assessments that we undertake. In that system you have reports of very vulnerable babies competing with children across the spectrum of ages right through to vulnerable teens.

We know from our own child death reviews that the vulnerability peaks for really young babies and for young people at the point at which they are gaining enough independence and that they can present themselves into situations that pose risk. While I think it is appropriate that we are a point that could perhaps identify the risk—and we do that currently—there are challenges in a stretched system being overloaded by that responsibility. We have to be able to plug in with relevant services quickly to support children. However, in regard to identification we are one of the places where it is raised that we might have information that a child is at risk of harming themselves.

The ACTING CHAIR: When you are placing children there must be some children who are identified as already being at risk. What are the factors you would look for in the family you have placed them to ensure that they are best able to deal with it?

Ms SWINFIELD: There are specific procedures and policies around recruitment, training and support of foster carers as they are getting to know children and young people in their care. FACS has its own procedures and processes and also non-government organisations who are contracted to provide out-of-home care have theirs as well. There was a recent comprehensive, independent review into out-of-home care which was commissioned by the New South Wales Government. That review is recommending some radical changes which I think will address some of the gaps in this particular area.

The ACTING CHAIR: In recruiting appropriate foster parents?

Ms SWINFIELD: Yes. One of the big challenges has been that most children who are in out-of-home care have come from very challenging circumstances. They have a lot of trauma-related symptoms that present challenges for their care. The training for foster carers has been to try to support them to manage those behaviours. I think the reforms, and funding is coming through the reforms, will enable trauma treatment for children in out-of-home care who are at risk of placement breakdown. Where it comes to our attention that children who are in placements have real behavioural difficulties related to the trauma that they have experienced they will get access to much more specialist intervention and support. That will also be targeted to the carers because ideally we want the support to be towards the carer as well as the child because they are there 24/7 and that will help them more adequately to manage difficulties.

The ACTING CHAIR: Part of that process would involve talking to foster parents about services that are available to them to access for the purposes of ensuring that the child who is potentially at risk does not do something that is life-threatening. How do you identify the best providers of those services?

Ms SWINFIELD: The preferred providers would be people who are specialists in adolescent mental health. As I said before, headspace and child and adolescent mental health. However, it probably boils down to what is available as well in any local area. In some areas I think there is a real lack of adequate service.

The ACTING CHAIR: The converse of that is—the Hon. Greg Donnelly raised this with other witnesses—that a lot of services appear to overlap where organisations have competed for grant money to provide services. Potentially you can have two organisations providing similar services to foster parents. I suppose you could tell them, "Here are two potential service providers", without making a value judgement about which one is the best.

Ms SWINFIELD: It probably does vary from area to area.

The Hon. WES FANG: Could you elaborate on the "Their Futures Matter" reforms and the impact you hope that will have on improving out-of-home care services for vulnerable children?

Ms SWINFIELD: Yes. Is there any particular aspect of "Their Futures Matter" that you would like me to refer to because it is quite a broad, all-encompassing and major reform. Would you like me just to outline it?

The Hon. WES FANG: We are interested in those parts relating to vulnerable children in out-of-home care. Do you believe that they will assist in protecting them? Where do you think that will lead to in the future?

Ms SWINFIELD: It is a radical change in the way that we deliver services in the system. I will outline some of the key aspects of it. In working towards family preservation and restoration, one of the things that is exciting about these reforms is that it will provide some intensive multi-systemic therapy for child abuse and neglect and functional family therapy focusing on child welfare needs. These are evidence-based programs that have been acclaimed internationally. The aims of those particular therapies are to reduce entries into out-of-home care and increase exits from out-of-home care so people are able to be restored to their family of origin. All the while those services must be able to respond to the underlying causes of child abuse and neglect—some mental health, parents' own experiences of trauma that may be linked to their substance misuse, domestic violence and the ways in which they are parenting their children.

These are intensive forms of therapy which have not previously been available. One of the big challenges for us has been that the services that have been available have not been able to work with our client group which often is quite involuntary and has a range of complex needs. That is kind of exciting because, potentially, if there are services that are available that can actually address the underlying risk issues, ideally children will not be placed in out-of-home care. We know what happens in out-of-home care. The outcomes have not been really favourable by and large for children in the out-of-home care system. There also will be a Their Futures Matter implementation board, which will comprise the Department of Premier and Cabinet, Treasury, our department, the Ministry of Health, the Department of Education and the Department of Justice. We will be working very closely under this board to develop an unprecedented level of cross-cluster collaboration to implement the reform work.

My understanding of this is that there will be opportunities to take more of an investment approach—looking at data of particular cohorts of vulnerability—so that this opens up the possibility for service provision to be funded to particular cohorts of people; that is, people who would not necessarily come to the attention of the Department of Family and Children Services [FACS] until perhaps sometime down the track. That is also exciting in terms of earlier intervention and the potential to address problems more directly earlier on in the light of the problem. The other piece that is related to that, I guess, is looking at population analysis, looking at cohort analysis, and trying to use the information that is available across governments to identify need more efficiently and cleverly. I think those are reforms that will make a big difference.

The Hon. WES FANG: The Committee has received evidence of different approaches to talking about suicide. Can you outline what you consider to be an appropriate way to talk about suicide in the community, in schools and in the media?

Ms SWINFIELD: I am not an expert on the topic of how to talk about suicide in those areas. But certainly, from my experience in working with and reading the child death reviews, I am very aware of the issue of contagion. As a parent, I am also aware of how children and young people use social media these days, so managing contagion is quite a big issue. I think we need to be sensitive but I think we need to be up-front and open when we are having conversations with young people. We need to certainly acknowledge, in particular, the experiences and pain and trauma that young people may have experienced and try to get them to get the help that they need.

In answer to your question about those other audiences, I think we need to tread a line of taking the issue very seriously and trying to encourage, through those messages, young people to feel like they will receive an empathic and helpful response if they seek help, and to let them know that there is help out there to present some hopeful and good news stories on children and young people who have actually survived this and have come out the other end. I think using youth advocates and young people to talk about their experiences of coming through this is probably very helpful because young people listen to young people in a way that they do not listen to us.

The ACTING CHAIR: Are there any protocols relating to the service providers like Lifeline and the Kids Helpline that can identify whether the child already has come to the attention of your organisation, or is in out-of-home care?

Ms SWINFIELD: To my knowledge, no. There is certainly the option to exchange information under legislation when the interests of a child and when the safety and wellbeing of a child are at risk. We can seek information from other agencies when we are worried about the wellbeing of a child and other agencies can seek information from us and each other.

The ACTING CHAIR: It would help you, though, if that data were available from them immediately, if in fact a child who was talking to them was happy to disclose, "Yes, I am in out-of-home care", or alternatively, "There is a FACS worker who comes and visits my house regularly." Do you get that sort of data?

Ms SWINFIELD: No. I think those two services that you referred to would often not collect information about the identity of the child because they are anonymous. Would it be helpful? Possibly.

The ACTING CHAIR: One of the things the Committee is exploring is that data appears to be siloed a bit in the sense that the Coroner keeps it, the Australian Bureau of Statistics [ABS] keeps it, and there are other organisations that have data available but not necessarily shared among organisations in a way that will enhance the delivery of services to children who are at risk.

Ms SWINFIELD: I am just thinking about in what circumstances that would be helpful because if the risk that has been identified is about suicide, then what comes to our attention would probably be about people wanting some sort of statutory intervention to help the child get the help that they need.

The ACTING CHAIR: Potentially, one of the best providers of help might be a caseworker.

Ms SWINFIELD: Yes, that is right.

The ACTING CHAIR: If I am in Lifeline or Kids Helpline and I take a call in circumstances in which they can identify in some form that this is a child who already has come to our attention or is in out-of-home care, that would be worthwhile because that person, the caseworker, would be an ideal person to contact to say, "We have a problem."

Ms SWINFIELD: Yes, absolutely. I am thinking that if the service were able to identify the child and get identifying details—age, address—they would probably be mandated to report because that would be a

report around a risk of significant harm. Thinking through your example, if that agency were able to glean the identifying details from the caller, that is probably how it would come to our attention—via a report.

The ACTING CHAIR: I am probably not expressing this all that well. Every report potentially to the Kids Helpline or to Lifeline by a child effectively is a child at risk.

Ms SWINFIELD: Absolutely. But it is a call; it is not a report, so the child themselves would be calling, or someone would be calling on their behalf, worried about them. This is probably semantics, but in terms of reporting it, you need identifying information that we could then follow up. If it is an anonymous call, then we cannot really do anything with that information.

Ms JODIE HARRISON: You mentioned some pilot training or some training that is happening for FACS workers in this particular area in the Hunter area.

Ms SWINFIELD: Yes. We received some seed funding to establish a child protection academy to train caseworkers more comprehensively in relationship-based practice. We are rolling out a pilot with the seed funding in the Hunter and New England districts. That involves using group supervision so that people can come together to share the cases within their team, guided by a group supervisor and consultants in the group, to reflect on some of the complexities of the work that we are doing in the cases to identify risks, to identify protective factors, to identify grey areas and things that need further follow-up.

Group supervision is a forum where we can also bring in other local agencies to consult on cases to help build the skills of our staff but also to raise awareness across agencies on how we work and how we can work with them to provide a better service for the children and young people that we are working with and their families. Alongside group supervision, there will be a range of modules on how to work with children and young people and their families in a more skilled way to try to engage them in effective change to reduce the risks that children are facing. It is implementing our New South Wales child protection framework and the capabilities that are under that on child and family safety-centred practice, family finding, motivational interviewing and a number of other capabilities. It is based on a number of key principles around providing dignity and social justice in terms of the ways we are intervening.

Statutory child protection the world over has been very much forensically driven and investigatory. Through the seed funding and training, we are trying to development a skill set for our staff to move from that forensic, investigative approach—which only suits a small number of our cases—to a more relationship-based practice approach that engages people who are quite fearful of our services in conversations that can lead to real change and plug people into services that can help. There are very big issues with bridging the gap around trust and building trust with our Aboriginal clients who have had a long history with our department. I think these approaches are very promising in creating a different way of working that is a little more empathetic and understanding of the problems that people are facing in their lives and getting them help that they need to try to address those issues.

Ms JODIE HARRISON: How far down the road is that program? When did it start?

Ms SWINFIELD: We have just commenced in the New England district and there is a plan to start the rollout in the Hunter in March. The rollout of the subsequent training will be over a period of a number of months so that people are not taken away from their frontline duties in one big block. They attend training and their group supervision on a weekly basis.

Ms JODIE HARRISON: Is group supervision considered an addition, separate to someone's current day-to-day duties? At the moment, if you are a Department of Family and Community Services caseworker not in the New England area, there is no group sharing. That is my assumption.

Ms SWINFIELD: There will be. There is a rollout of group supervision that is occurring across the State. By June 2018, there will be group supervision rolling out to all CSCs across the State. The other aspect of the rollout that I talked about as part of the seed funding are subsequent modules that build on and use group supervision to maximise the impact and effect of building those capabilities in our staff. It is something that we would like to roll out more broadly. We would also like to extend the ongoing skill development that our frontline child protection caseworkers, out-of-home care caseworkers and their managers receive. If we were in a position to fully fund this approach, it would be an investment in the ongoing skills development of our staff. At the moment, there are big gaps in the skill development that people receive when they come into the department around having hard conversations with involuntary clients. We could certainly use much more time in the entry-level training around relationship-based practice and doing good skills-based work before you have to go out to some of the hardest families to work with in an area. That is very challenging.

The Hon. GREG DONNELLY: Many submissions talked about protective factors regarding youth suicide. In your experience, what is the one protective factor that really stands out for children and young people against the potential of suicide?

Ms SWINFIELD: I will start by saying I am not an expert in youth suicide. In terms of child protection and risk, one of the things that stands out for our most vulnerable families and their children is disconnection—a lack of connection and a lack of a safe network. When I say a safe network, I mean a network of perhaps services and community supports that can buffer families against adversity. Children and young people in out-of-home care suffer extreme loneliness. It has been referred to by people like Kevin Campbell from the United States as a form of social quarantine. Children in out-of-home care do not have the normative experiences that children who are not in out-of-home care may have—things like being able to go out with their friends, have a mobile phone or attend after school activities might not be available to them. Typically their calendars are quite empty of things that are not included in paid care, such as the sporting activities and community-based activities that other children might experience. They may not have access to friendships and so on in the same way.

The loneliness that children in out-of-home care suffer places them at extreme risk for a range of mental health issues and the lack of connectedness that parents in the child protection system experience places them and their children at risk. One of the key measures we try to take to increase protection is to build a safety network around the family and child. It is a complicated question you have asked and I do not think I have attended to it very well, but the risks for—

The Hon. GREG DONNELLY: Without cutting you off, I find it interesting that you included the capacity of the child to be involved in sporting activities and the issue of the parental relationship in the same basket. It strikes me as strange that those two things could be considered the same in terms of impact on the child. I would have thought the issue of the parental relationship—the biological mother and father being in a stable long-term relationship—would be a stand-out factor in protecting a child as opposed to virtually anything else.

Ms SWINFIELD: Absolutely, and I am sorry if I have not been clear. The children in families who are reported to FACS certainly are experiencing some difficulties in terms of the parental risk factors—usually domestic violence, mental health and/or substance misuse, and often all three. Those things are certainly the things that set children up who are reported to Family and Community Services to be at greater risk of mental health issues generally, but also suicide risk and self-harm. They are very important childhood adverse experiences that have lifetime consequences in terms of mental and physical health for children. Having a loving parental relationship or care-giving relationship certainly is a really important protective factor for children. It does not mean that they might not experience other adversities or other—

The Hon. GREG DONNELLY: Events in their life.

Ms SWINFIELD: Yes, or perhaps be prone to genetically related mental health issues or whatever. But in terms of people's experiences and the environmental factors, definitely. A consistent, loving relationship is very, very important for children.

The ACTING CHAIR: Thank you very much. The Committee may feel disposed to ask you additional questions. I take it you are happy to answer those questions if we give them to you in writing?

Ms SWINFIELD: Certainly, yes.

(The witness withdrew)

(Short adjournment)

ROBYN BALE, Relieving Executive Director, Learning and Wellbeing, NSW Department of Education, sworn and examined

PAULINE KOTSELAS, Leader of Counselling Services, NSW Department of Education, sworn and examined

ANNE REDDIE, Director, School Services, NSW Department of Education, sworn and examined

The ACTING CHAIR: Thank you for appearing before the Committee today. I note that you were here during the evidence given by the Department of Family and Community Services representatives, so you would know the protocol followed in these hearings. I assume you have received information packs dealing with committee procedures. As you are aware, the Committee invites witnesses to make an opening statement in support of their submission.

Ms BALE: That is my role. I acknowledge the traditional owners of the land on which we meet today, the Gadigal people of the Eora Nation, and pay my respects to elders past and present. I extend that respect to Aboriginal people here with us today. On behalf of the Department of Education, I thank the Committee on Children and Young People for the invitation to give evidence to its inquiry into the prevention of youth suicide in New South Wales. We welcome the inquiry and look forward to the Committee's insights gathered from submissions and witnesses. We also look forward to hearing about your findings and receiving the final report.

The suicide of a child or young person is a tragedy that has a devastating impact on their family and a long and lasting impact on friends, peers, the school community and the broader community. We know that suicide is the leading cause of death of young people between the ages of 15 and 17 years. We also know that we need to look at universal approaches, prevention, early intervention and postvention when it comes to suicide. The Department of Education is committed to preparing young people for rewarding lives as citizens engaged in a complex and dynamic society. The NSW Department of Education Strategic Plan 2018-2022, which was released recently, has 10 important goals which are the focus of our work and which demonstrate our increased attention to student wellbeing for all schools, for all policy areas, and for all staff within our organisation. I will share a few of the goals that I believe are important in our current work and to our focus on wellbeing.

Every student is known, valued and cared for in our schools. Every student, every teacher, every leader and every school improves every year, and every student is engaged and challenged to continue to learn. We have undertaken considerable work in New South Wales public schools in respect of the wellbeing of all students. It is a universal approach. We have also undertaken considerable work on suicide prevention. Encouraging resilience among children and young people promotes their ability to cope with adverse life events and provides a sense of hope for the future. School-based programs that promote resilience and provide support to children and young people can reduce the risk of suicide. Since 2015, the department has had an increased focus on the wellbeing of all students and has devoted considerable planning and additional resources to support student wellbeing.

The New South Wales Government's $167.2 million initiative called Supported Students, Successful Students includes funding for 236 additional school counselling positions and to increase the capacity of school counselling staff through a range of scholarships and other training opportunities. The school counselling service provides expertise and advice to school staff in identifying and responding to mental health issues in children and young people. That service is a component of an extensive network of staff who provide wellbeing services in our schools, but it is not the only component. We recognise that a variety of positions and services can support schools to meet the wellbeing needs of their students—the school principal; the school executive; year advisers; classroom teachers; youth workers; counselling staff; and, importantly, structures such as the learning and support teams in every public school. The Supported Students, Successful Students package includes $51.5 million of funding allocated to schools over four years specifically for wellbeing services. Schools are able to use this funding to employ a range professionals with expertise in psychology, social work, youth work, and community work to support their students. They look at the students' needs and pick the required mix of services.

Targeted support for Aboriginal students and refugee students and funding to support whole-school wellbeing initiatives such as Positive Behaviour for Learning are also included in this package. In 2015, the department released the Wellbeing Framework for Schools, and since then all public schools have been required to have a planned approach to wellbeing. In 2017, a wellbeing self-assessment tool and professional learning package was provided to assist schools in assessing their current wellbeing approaches and to identify areas of future growth. It was developed with school staff, piloted in a small number of schools and then released for use by all schools as they review and plan their approaches to wellbeing. Wellbeing is also supported in New South

Wales public schools through the curriculum and a range of whole-school, evidence-based integrated programs such as MindMatters and KidsMatter, which are designed to promote resilience and mental health.

Education relating to mental health and wellbeing for students from kindergarten to year 10 is included in the mandatory Personal Development, Health and Physical Education curriculum. It is provided within the broader context of personal health choices, self and relationships, and individual and community health. To complement the curriculum, senior students in New South Wales government schools participate in the NSW Crossroads Program. This is a 25-hour course that extends student knowledge, understanding, skills and attitudes in respect of personal identity, mental health, and wellbeing. Schools play a major role in supporting children and young people with emotional and behavioural problems. It is often in the school that the symptoms of mental health problems in children and young people are first identified. Early identification of mental health problems can reduce the potential burden and impact on a young person's quality of life. This view is reflected in some of the submissions made to the inquiry.

School staff are well placed to notice when students may be in need of extra support. The 2015 report on the second Australian child and adolescent survey of mental health, "The Mental Health of Children and Adolescents", found that a skilled staff member was among those to suggest that some help for emotional or behavioural problems was needed in 40.5 per cent of cases. We have been working hard with our school counselling workforce and our school staff more broadly to provide trauma-informed practice and training, which is particularly important for those children and young people in our schools who may be vulnerable.

It is important that we do everything we can to prevent youth suicide. Our department has undertaken and initiated significant work in this area over the last three years, and our work continues. The NSW Child Death Review Team annual reports show that the factors that contribute to a young person tragically taking their own life are varied and very complex. Suicide prevention requires a system-wide and multifaceted approach. The department is working closely with partner agencies such as the Ministry of Health, the Mental Health Commission of New South Wales, the Black Dog Institute and headspace in schools to implement a coordinated approach to suicide prevention and postvention.

In 2015 at the request of the commission the Centre of Research Excellence in Suicide Prevention, known as CRESP, developed a detailed plan for how multiple proven suicide prevention strategies could be rolled out in New South Wales in a coordinated and effective way. The result of this work is the proposed suicide prevention framework for New South Wales. Our department actively contributes to this work and is represented on both the statewide Suicide Prevention Advisory Group and the suicide prevention framework subgroup working party. Using the research from CRESP, the Black Dog Institute secured funding to run a suicide prevention trial in New South Wales called LifeSpan. We have been very keen to partner with Black Dog in this work. LifeSpan is a new evidence-based approach to integrated suicide prevention. It combines nine strategies that have strong evidence for suicide prevention into one community-led approach incorporating health, education, frontline services, business and the community. Based on scientific modelling, LifeSpan is predicted to prevent 21 per cent of suicide deaths and 30 per cent of suicide attempts.

We know from young people themselves through large surveys such as the report on the second Australian child and adolescent survey of mental health, "The Mental Health of Children and Adolescents", and Mission Australia's annual youth survey that mental health and wellbeing are identified as key issues. Many young people disclose their feelings of distress to other young people before they disclose to an adult and sometimes instead of disclosing to an adult. They feel safe with their friends. Normalising help, seeking and promoting confidence in young people to know where and when to get help for themselves or their friends is the key factor in intervening early. This is one reason that Youth Aware Mental Health, which we call YAM, was chosen as one of the key strategies within the LifeSpan integrated approach to suicide prevention.

YAM has the strongest evidence for reducing suicide attempts and ideation, and facilitates healthy lifestyle choices and help seeking among young people. It is a mental health and suicide prevention program specifically for young people of 14 to 16 years of age. YAM improves mental health literacy and teaches the skills necessary for coping with adverse life events and stress so that young people get help before reaching a crisis. Many of the programs are around support for teachers to identify vulnerable children. YAM is actually working with children and young people to help them identify their peers that may need help or when they might need help themselves.

In May 2017 the department established six head teacher positions to lead the implementation of the YAM program in the LifeSpan sites. There has already been a positive response from the year nine students and teachers at the schools where YAM has been implemented. The student voice is a key component of the YAM program and our young people have actively engaged in the content and have really valued the opportunity to speak about topics that are important to them. We heard about social media in some of the previous questions.

Only last week we heard from one of our YAM facilitators that they turned up at a school after a series of YAM sessions in schools in this geographical area and when they turned up some young people came up to the facilitator and said, "Did you present in this school yesterday and the day before?" And they said, "Yes." And the students said, "We heard in social media how good this program is and we were told to make sure we came and attended." Those positive insights from kids were really encouraging.

The submissions from Orygen and the Advocate for Children and Young People both made reference to the importance of information and conversation specifically for students. YAM provides an opportunity for students to open up and share their points of view in a non-judgemental and safe way and allows deep conversations in order to explore options when faced with a problem and to develop skills in help seeking for themselves and also their peers. Gatekeeper training is another area that has been mentioned in submissions and also here today. Another strategy in the LifeSpan approach is gatekeeper training. The department is working with the Black Dog Institute to make Question, Persuade, Refer, or QPR—an online, evidence-based gatekeeper training program—available to school staff.

QPR has been shown to lead to positive outcomes on knowledge about suicide, intentions to intervene and confidence in helping someone identified as being suicidal. Our department has also engaged directly with the Black Dog Institute to customise their existing accredited advanced training in suicide prevention workshop for the high school context. We want bespoke training for those that are working with young people in our schools. The Black Dog has agreed to assist us with that work. This training will be provided for our whole school counselling workforce with the aim of increasing the skill of our school counselling staff to manage and support students who may be at risk of suicide or attempting suicide.

Research on suicidal behaviour in young people has shown that exposure to suicide can trigger suicidal behaviours in others. In fact, young people are more vulnerable to suicide contagion than any other group. I think that is referred to in submissions as well. Should a student tragically take their own life, school staff are supported to respond in a sensitive, evidence-based manner. All public schools in New South Wales are required to have an emergency management plan. In the event of an emergency, including suicide, attempted suicide or self-harm, schools will implement a coordinated response in line with their emergency management plan.

In 2015 our department in collaboration with the Ministry of Health and headspace released the resource responding to suicide support guidelines for schools. Our departmental directorates and agencies such as headspace and health work together with schools when there has been a suicide attempt or suicide of a student. The relevant director of public schools New South Wales is notified, as are staff in other areas of the department who provide to schools, including learning and wellbeing, health and safety, legal services and our media unit. This enables a comprehensive and timely response, facilitates wraparound support for the entire school community, and helps to reduce the likelihood of suicide contagion.

In addition to the local partnerships with government and non-government agencies, the department, NSW Health and headspace school support have an agreed process to notify each other when advised of a suicide. This process alerts specialist staff from each agency. For example, it enables relevant departmental areas to mobilise and wrap support around a school as necessary and provide additional resources, guidance and support as required. It alerts the Child and Adolescent Mental Health Services [CAMHS] teams to a potential increase in risk to vulnerable children and young people in the community and possibility of increased demand for their services. It also facilitates headspace in schools in reaching out to the principal to offer support in developing and implementing postvention response. We know that in a critical emergency such as this, support from other agencies reaching out to the school can make the role of the principal a bit easier as they navigate the many issues that emerge.

It is important that children and young people have timely access to support systems when they are experiencing psychological distress. The school counselling service provides a mechanism for young people to self-refer as needed, which is particularly important for those children in the high school years. Children and young people can experience life circumstances such as a family separation, peer conflict, bullying, trauma, grief and loss that can result in psychological distress. For students experiencing psychological distress, intervening early will reduce the likelihood of those young people developing a mental health problem. We know that students who are involved in bullying behaviour, either as the person bullying others or the person being bullied, are at higher risk of behavioural, emotional and academic problems. We have undertaken considerable work in recent years to assist schools to implement proactive responses to bullying behaviour.

Our current New South Wales budget is providing $6.1 million in new funding over three years to support an updated anti-bullying strategy. As part of this strategy a web site was released in July last year that brings together evidence-based resources for schools, students and parents. It also includes funding to expand our Youth Aware of Mental Health program to other schools across the State. We have increased our facilitator

positions from six to 16, enabling many more students to participate in YAM. We acknowledge that social media is a significant part of our students' lives, and can have a powerful influence that can be a potential for both positive and negative effects. Our anti-bullying website has a section specifically on online bullying or cyberbullying. It also has information about where students and parents can go to for help, particularly after hours.

Our digital citizenship site provides important information for students, teachers and parents about digital citizenship and being safe, positive and responsible online. This site is currently being redesigned and a new site will be available in mid-2018. As I have outlined in my opening statement, the department has a strong focus on student wellbeing, and is active in providing support to New South Wales public school students through a range of initiatives, partnerships and evidence-based programs to support the wellbeing of all of our students, and provide specialised support to our most vulnerable. We are looking, and will continue to look, at the evidence, and at ways we can improve and increase our support in this important area.

The ACTING CHAIR: That was very comprehensive. I invite you to table that opening statement. I am sure Hansard has recorded it all, but it might be helpful if you provided us with a copy.

The Hon. GREG DONNELLY: Thank you very much for coming along today. I have a copy of the New South Wales Government submission to the inquiry. It is submission No. 46. Do you have a copy of that?

Ms BALE: Yes, I do.

The Hon. GREG DONNELLY: I specifically want to go to page 13. Do you have that?

Ms BALE: Yes.

The Hon. GREG DONNELLY: I will give you a couple of moments to read paragraph 5.3.5.

The ACTING CHAIR: Have you read that?

Ms BALE: Yes.

The Hon. GREG DONNELLY: Standing alone, the numbers look impressive. My question is about the ongoing challenge that we all face with respect to the term that we have all heard—silos. Across different government departments there tends to be vertical integration of information about what is going on. We just heard evidence from a representative of FACS. As I am sure you know, after you we will hear from representatives of NSW Health. Can you explain those numbers to me, particularly the 133 senior psychologists. Are they working with NSW Health in any way? If they are, could you explain that? FACS obviously deals with children and young people who have various difficulties and challenges. Are you talking to that department? If so, could you describe what happens?

Ms BALE: I will start off, and then I might pass over to my colleague, Pauline, who is a tremendous manager of our school counselling workforce in public schools. We have been very pleased to have our school counselling workforce increase from 790 positions to 1,026. That has been a tremendous boost in support for students in our public schools. As you have mentioned, we have 133 senior psychologist positions that provide a supervision structure for our counselling workforce. Our colleague from FACS talked about the supervision structures that they have in FACS.

In the same way, each of our senior psychologists have a team of seven or eight counsellors that they work with on a regular basis to support their supervision—and that structure that is required for registration of a psychologist—but also to build the capacity of the team, debriefing, looking at case presentations, and discussing ways in which they can respond to individual children and young people in schools. Alternatively, they look at a cluster of schools or a group of students for which they might need to have particular discussions and seek support across their team. In the last 12 months we have increased that work, and we now have 10 leader positions that sit within schools that have—

The Hon. GREG DONNELLY: Sorry, I will pull you up. You are not even getting close to answering my question. I was talking specifically about the connectivity between what I am looking at there and what is going on inside FACS. What is that connectivity? What are the discussions and the channels of communication between the two departments to deal with matters of youth and child suicide? That is the first part of my question. My second part is with respect to NSW Health. What is going on in that regard?

Ms BALE: Sure. I was about to finish there—and I will—and move onto NSW Health and FACS. I will give an example. We have a very strong process in place working with NSW Health through a program called School-Link. My colleague Pauline can describe that. I will talk about one example of our work with FACS—our counselling staff and their counselling staff. I heard you talking about very vulnerable kids, particularly those in out-of-home care. Over the past 12 months we have been working in a whole-of-

government sense, focusing on some of those children and young people who are the most vulnerable in New South Wales. We have taken a really deep dive into a group of vulnerable kids in out-of-home care, looking at their background information, schooling, attendance and support.

We are looking at what we are providing within the School-Link system and what other services are being provided beyond that system. One of the activities that has come out of that work is our school counsellors working with FACS psychologists to provide trauma-informed training in each one of the schools which those young people are attending. That has been a collaboration that has been implemented over the last 12 months, looking at a particular cohort of kids that are quite vulnerable. Our counsellors are working with FACS counsellors to provide some really good ground training for the staff in the schools which these students are attending.

The Hon. GREG DONNELLY: Is that across New South Wales?

Ms BALE: That has been a particular cohort. It has not been statewide, but it is in more than the Sydney metropolitan area.

The Hon. GREG DONNELLY: Where has it been?

Ms BALE: I would have to look at the individual students. It is over a fairly broad area of New South Wales, but I cannot say that the program has been statewide.

The Hon. GREG DONNELLY: Do you know how many students are caught by this program?

Ms BALE: This first cohort of students was around 69 children, and potentially 69 different schools. I am not sure of the number.

The Hon. GREG DONNELLY: Can you provide on notice some details about this?

Ms BALE: We certainly can—within levels of confidentiality, of course.

The Hon. GREG DONNELLY: I appreciate that, and if you need to redact, you need to redact in terms of schools and names. Was this done on a trial basis? Is it being evaluated now?

Ms BALE: We have been trying to look very carefully at those young people who are most vulnerable in out-of-home care, in particular. I know that our colleague from FACS reported about Their Futures Matter. It is part of that work. We have been looking at different cohorts of children and young people to see what we can do better and differently, and how we can have a joined-up service with other agencies to provide a more coordinated approach for them, so that it is not a siloed approach.

The Hon. GREG DONNELLY: Has the program you have just referred to been evaluated, or is it being evaluated at the moment? Is a judgement being made about whether—

Ms BALE: We are in the process of doing that now.

The Hon. GREG DONNELLY: When will that evaluation be complete?

Ms BALE: During the course of 2018. I do not have a date, but I can provide that for you.

The Hon. GREG DONNELLY: Thank you. That is an example of what I am trying to get to in terms of the departments. It would be a terrible situation if one department, through a particular agency, is dealing with a matter first-hand and yet another agency—and it is not a criticism of the agency—is blind to what the other agency is dealing with.

Ms BALE: Yes, indeed. I will say, though, in relation to child protection generally—and they are many of our most vulnerable children—we have an established process in New South Wales that is working really well with sharing information. We have Child Wellbeing Units in Education, in Health, there is one in Police. They share information on a daily basis about children and young people who might be vulnerable. In terms of reporting child protection concerns, there is a Mandatory Reporter Guide and one of the trees is about self-harm. Reports will be made, either to one of the Child Wellbeing Units or the FACS. That information is recorded and shared. It is not that information is not being shared. This might not be known to you, but there are ways in which Police, Health and FACS are sharing information on vulnerable children, and picking up and looking at what they need to do to support the child in the school setting or in the home setting.

The Hon. GREG DONNELLY: What about Health?

Ms BALE: Yes. Ms Kotselas might like to go through the School-Link work that we have been—

The Hon. GREG DONNELLY: Thank you.

Ms KOTSELAS: School-Link is a partnership between Department of Education and NSW Health, with a real focus on mental health and intervening early. It has a whole range of different components to it. Some of it is developing professional learning for school counselling and Child and Adolescent Mental Health Services [CAMHS] workers, and also developing programs that we do jointly on building the capacity of teachers in schools to identify vulnerable students. One example of that project is Project Air. We have worked with the University of Wollongong as well as NSW Health to upskill school counsellors and then have school counsellors deliver training to high school teachers on identifying students that may be at risk of self-harming, suicide and personality disorder.

That is just one example. At the primary school, we also work jointly on a program called Got It!—Getting On Track In Time—which is a program for students in kindergarten to year 2 that are at risk of developing disruptive behaviour disorders and trying to change that trajectory, obviously, at an early age because those young people then become vulnerable of death by suicide because they are quite impulsive. That was evaluated early on and has been expanded to each local health district. They are just a couple of examples of our work that we do together.

The Hon. GREG DONNELLY: That is good.

The ACTING CHAIR: If one of those programs potentially identifies a child at risk, what is the protocol for counsellors to talk to parents?

Ms KOTSELAS: If a student is identified as being at risk of harm, that is a conversation that counsellors have at the outset when they have a counselling relationship. Obviously confidentiality is critical to young people, so from the outset that conversation occurs and confidentiality is spoken about, but the limits of confidentiality are explained to the young person so that they know that if they talk about potential harm to themselves or others, that they have got to take action to keep them safe. If the harm is not being caused by the parents—sometimes that can happen. If there is risk to the young person and the parents are obviously supportive—and that is the case in most instances—obviously we work with the family and other agencies to put in safety plans to keep that young person safe and help them improve their wellbeing.

The ACTING CHAIR: So a school counsellor would pick up the phone to the parent?

Ms KOTSELAS: Absolutely, would ring the parent, invite them to the school. That would be negotiated with the young person in many cases. Obviously, you want the young person to have some say in how that information is relayed. That might be done with the parent and the young person together. Sometimes that might increase the risk for the young person, so it might be done with the parent on their own. Each case is different and, obviously, as Ms Bale has mentioned, we are doing a lot of upskilling of the counselling workforce on managing students at risk of suicide through this training. It is looking at using a different response in each situation, depending on the needs of the young person.

The ACTING CHAIR: You have sung the praises of the YAM program. Can you give more detail about how it operates? What is the content of it? How would you deliver that program to a school or to the counsellors?

Ms KOTSELAS: I am not a facilitator, but we have trained facilitators. They do a five-day training. It is run over three weeks. The themes of the program are What Is Mental Health? The first session is a lecture on mental health with some everyday dilemmas that young people might face. There is a section on Self-Help Advice, Stress and Crisis, Depression and Suicidal Thoughts, Helping a Friend in Need, and Who Can I Ask for Advice? They use role-plays and young people can choose the role-plays, so they give them a number of options that they can choose from or the young people can choose role-plays themselves. They could role-play, for example, "I come home and my parents have had a huge argument. Dad is stressed and has slammed the door. What do I do?"

They act out those scenarios, and young people are given the opportunity to explore how they respond to those situations. There are no judgements in the room and the young people are the experts, so the adults really facilitate a conversation. I hear from all the facilitators how powerful it is and how young people really welcome the opportunity to talk about sensitive issues but in a very open and safe way that has been evidence-based through this randomised control trial that was done in Europe. Obviously there is going to be replication of that research in Australia, but the anecdotal feedback so far is that it has been quite positive.

It is run over three sessions over a three-week period. There is a lot of preparation that goes behind the delivery of YAM. We meet with the school beforehand to make sure we identify any vulnerable students, because it is delivered to all year 9 students so we want to make sure that if there are any vulnerable students in that year group, that they have an opportunity to know about the program, just find out if they are ready to be part of that conversation. So far we haven't had students that have opted out for that particular reason, but we

obviously have checks and balances to support the implementation of the program. Each program is run by a trained facilitator and a helper. They are not psychologists, necessarily; they are teachers. Some of them are school counsellors, but you do not have to be a psychologist to be the facilitator of the course.

The ACTING CHAIR: That is part of a package of programs that are available in school. There is LifeSpan, of which it is a component, I take it; there is safeTALK; there is headspace. There is a lot going on in schools. Are we asking schools to do too much?

Ms KOTSELAS: That is a really good question. I was here when Black Dog presented and they talked about three programs that they considered had the best evidence internationally. We chose this one. In conversation with them we thought it had the best evidence. The other reason we chose it was because external people that are trained and funded by the department can come into the school and run this over three sessions. So it is taking that—

The ACTING CHAIR: It is not teachers, necessarily?

Ms KOTSELAS: No. They are teachers that we have funded separately to run this program. It also gives young people the opportunity to have the conversation and not worry about what the teacher is going to think in the next lesson, so it has been shown to be more beneficial to have external people run this program. That is part of the reason we chose this program, as well as the best evidence for it.

The ACTING CHAIR: What is the different between that program and, say, headspace? What does headspace offer or not offer which LifeSpan would?

Ms KOTSELAS: This program is really a program to support peers to develop the skills to support each other, so it is a targeted program for all young people. It is not for kids at the pointy end—we have heard about those today as well. It is for all students because we know from research that, tragically, it is not just young kids with mental illness that go on to take their lives; it is young people with no identified risk factors. So we want to upskill all young people to be able to understand that life is a roller-coaster and we have ups and downs, so this program will hopefully give them skills to deal with those adverse life events. In terms of headspace in schools, it is really a postvention response. It really helps support schools with their postvention response to minimise that contagion effect that we have heard. It is a very different program to YAM, and headspace services provide a counselling service in various locations across New South Wales.

Ms JODIE HARRISON: YAM is over a period of three weeks?

Ms KOTSELAS: Yes.

Ms JODIE HARRISON: Is there any follow-up after that? How far along is the department in assessing its effectiveness and whether it will be rolled out further?

Ms KOTSELAS: At this stage we are still in the early stages. Our first cohort of people were trained in May of last year. We have had another cohort of staff trained. We have implemented in Newcastle and now we are in the Illawarra and Shoalhaven area. Central Coast will commence shortly and then the Murrumbidgee area. In terms of the evaluation, the Black Dog Institute is doing research which has been approved by our department to evaluate YAM. We won't know the outcome of that for some time. I know in the European trial they were looking at follow-up effects, say, 12 months later—students still had reduced rates of suicide ideation 12 months later. I think the outcome of that we will not know for some time because I know in the European trial they were looking at follow-up effects, say, 12 months later where the students still had reduced rates of suicidal ideation 12 months later. I think the research will be at least a couple of years to get, but I can take that on notice and ask Black Dog about that. I do not know if I have answered your question entirely.

Ms JODIE HARRISON: The question was about the follow-up after three weeks as well.

Ms KOTSELAS: We have these head teachers that meet with the school prior to the program being delivered. We also meet with the school at the end to give them feedback about anything that we think they should be following up on themselves. We also are looking at providing feedback to the schools about key messages so that they can reinforce those key messages in the school, say, in the curriculum—for example, the personal development, health and physical education [PDHPE] curriculum. This program tends to be run for those three weeks and then you step out, but you leave the school with some additional information about Youth Aware of Mental Health and the help seeking that we have been trying to promote in the program. The idea is that we will go back the following year and run it for the next cohort of year 9 students so we have targeted 14-year-olds generally because we think that is a good time to intervene.

Ms JODIE HARRISON: The follow-up is external to the YAM program within the department itself?

Ms KOTSELAS: Every student gets a YAM booklet. In the back of that booklet are localised services. We have been working with the primary health networks. They provide a list of all the services that are in that area, including some of those broader services like Kids Helpline and Lifeline, et cetera, but also local services like Aboriginal services, for example—whatever is relevant to the local area and not just health services but also community services that are relevant in that area, such as sporting services and the police citizens youth club. It is a very localised approach. Young people keep that book and then obviously they can go home and share it with their families. Parents get a letter about the program. We can present at the parents' and citizens' meeting as well so that the families understand about the content of the program as well.

The ACTING CHAIR: We heard from a United Kingdom company about monitoring students' email traffic and what they put in documents when they are using computers at school and the like. Were you aware of that evidence which we received?

Ms KOTSELAS: Yes, I had read the submissions so I was aware of that.

The ACTING CHAIR: Is the department interested in that sort of approach? Apparently it can identify, I suppose, words or phrases that people are using, which can be identifiers of potential self-harm.

Ms KOTSELAS: Our department is very focused on having an evidence-based approach. That is why we are very committed to LifeSpan. I am not aware of any particular evidence that that actually reduces suicide rates. I think, for young people, trust is such a huge issue, so I think inadvertently that may create issues. But I am speculating because I do not know the research behind that particular program.

The ACTING CHAIR: They rely on, I suppose, research from the UK where they say that we live in an age when young people do not care too much about who is looking. However, that evidence appears to be— that is what they tell us at any rate—that by monitoring their computer use at school, that can be a significant opportunity to identify circumstances when someone is at risk of self-harm. Apparently, it even was sophisticated enough to be able to identify when they were using through the school network a potential Gmail account or something at home and to be able to monitor that. It did not identify the student, but just the student's number who might be involved. Do you think that is a bridge too far?

Ms KOTSELAS: I probably would need to know more about it because, as I said, it is a bit hard to make a judgement call about something that would have such a widespread effect.

The ACTING CHAIR: The media concentrate a lot on the relationship between social media and bullying, et cetera. This morning we also heard that, potentially, social media certainly does engage in bullying but there are also great benefits in social media—not just social media, but devices —in the sense that they give access to help opportunities for young people. It is a two-edge sword. Is it the department's perception—and certainly it is in the news of late—that potential bullying via social media sites is a circumstance that is currently triggering potential self-harm?

Ms KOTSELAS: I think, as we have said a number of times and as you have heard, suicide is very complex and the reasons are so varied. Certainly bullying is one risk factor that is known or that may have some association in some cases. That is one risk factor. Social media can obviously have lots of benefits for young people in terms of increasing their help seeking. But certainly there are some difficulties that can arise from time to time with social media. There are a lot of things that we are doing, I know, in terms of the anti-bullying space to support that.

The ACTING CHAIR: In fact we heard over the weekend that there is a potential opportunity for school principals to exclude children from the school, if in fact even activity outside the school was interpreted as bullying behaviour. In those circumstances the child could be excluded from the school. Is that because we say that bullying has such a significant impact on, first, the child's mental health; and, secondly, potential to self-harm?

Ms KOTSELAS: We have always had, in terms of our policy, that if there is something impacts upon or is related to the school, we will do with that anyway, even if it happened at home. We obviously just do not pretend it did not happen. Obviously, if there is an impact on the school we will look at ways to either support that young person to change their behaviour or put in some consequences that we believe will support the whole school.

Ms BALE: I think our department has done quite a lot of work in the area of bullying and also nationally for quite a number of years, but we have put renewed energy and effort into anti-bullying and reviewing our anti-bullying approach during the last year. We released our new website, which I referred to in the opening statement. It is a cross-sectoral anti-bullying strategy, so it is across both the government and non-government schools. What was really important with the development of those materials is that we had three

academic experts in the area that helped and guided our work. For the materials that we developed, we worked with the three academic Australian experts to endorse and approve each one of our resources before they were published. We worked with the eSafety Commissioner. Cyberbullying or online bullying being an emerging issue, it was something that we felt was really important to do.

That website has been released and we have been continually updating materials or adding more to it as we go. There is a specific section for students, a specific section for parents, and a specific section for teachers as well. What we are actually doing is working with young people and I think we have three, four or five video clips that students in our schools have come together and developed. They have been published on our website. They have a scenario about bullying and what the impact is and how they should respond. It also focuses on the positive behaviours that should be exhibited by young people in our schools. That has been a new introduction during the course of last year.

We know our website has had well over 200,000 hits, with many of them being return visitors, which I understand from our media folk is a good sign that resources are being used or that our website is being used—when you get those return visitors. What we have also done as well—because we know that Facebook and Instagram and some of those areas of social media very popular with kids—is work with the Office of the eSafety Commissioner. This year in February we held our first Facebook live session with the Office of the eSafety Commissioner. That live broadcast was viewed by more than 37,000 people, which was quite exciting. We have also held to virtual classrooms this year about online safety, and that was also done with the Office of the eSafety Commissioner. Across New South Wales more than 600 schools participated in that.

We are really looking at different ways of getting to children and young people to promote the positive aspects of social media but also to talk about how they can be safe online, how their peers can be safe online, and where to go to get help when you need that. Just talking about hearing from other agencies about monitoring social media, we have a very active communications and engagement and media area within our organisation. We have active Facebook and Twitter pages that the media staff are constantly monitoring. When there are young people or families who appear to be in distress we have a process in place where our media people go in and ask the young person or their family to private message us. We then take the issue off line and talk to them directly, either through social media or through contact with us. That is something that we have introduced over the last 12 months because we understand that kids respond to and interact with each other in different ways, with social media being one of them. It is important that we too can engage with the mediums that young people are using in their social life.

The ACTING CHAIR: Would you not want to know if there was a kid at a public school accessing Google or something else to search "How do I take my own life?"

Ms BALE: Without question—of course.

The ACTING CHAIR: Do you have the resources to be able to know that?

Ms BALE: I would have to take that question on notice and go to our media and communications team to come back to you with some advice.

The Hon. PAUL GREEN: I have a question about the training provided to teaching staff on identifying risk factors for self-harm or suicide ideation. What level of teaching is the training provided for—is it every teacher and librarian?

Ms KOTSELAS: One of the programs I mentioned was Project Air, which is for high school staff. That is available for all high school staff. Schools are also engaging in programs such as Youth Mental Health First Aid. We are also looking at making the Question, Persuade, Refer [QPR] gatekeeper training program that the Black Dog Institute is promoting available to all school staff and beyond to the community because it is very accessible. It is an hour-long online program. The program has the potential to upskill any member of the community to notice and respond to people who are in distress and potentially at risk.

The Hon. PAUL GREEN: I have been listening to the hearing in my office—I have been trying to do dual roles today. Some of the evidence suggested that the suicide issue is not necessarily a mental health problem. An individual may have no history of mental illness but is going through a bad situation, which is being reflected in statistics. Other statistics show that the number of children in homeschooling has gone up by approximately 1,000 this year. Parents are taking their children out of school to homeschool them, often as the result of bullying or cyberbullying. Are we over complicating the issue of teaching and training staff, given the fact that young people considering suicide have often lost hope, lost faith in themselves and have a lack of positive outcomes?

Is it too much to believe that if parents can pull their kids out of school so they can give them a positive environment and say "I believe in you", that we are focusing too much on training, rather than ensuring real people are available and accessible in schools, such as a chaplain or wellbeing program officer, who do not have five degrees in psychology but know how to befriend a young person? Are we over-complicating this when trying to address the issue?

Ms BALE: I am not sure we would say that we are over-complicating. As we discussed earlier, the issue of suicide is quite complex. Other people who have appeared before the inquiry have said the same. What we would say is that the issue you are referring to is one of the reasons why we have had a significant increase in wellbeing more broadly. We acknowledge that school counsellors are not the only people who should be helping kids; anyone within the school setting should be available to support, guide and help children through their schooling. In our opening statement, I said that one of the new goals for our current strategic plan is that every child will be known, valued and cared for. We believe that it is important for all children. You make reference to the student wellbeing program, which includes chaplains and youth workers. We do have that program and we also have the National School Chaplaincy Programme.

When the Government increased funding for school counsellor positions in public schools, which provided 236 additional counsellors, it was also recognised that there is a whole range of other wellbeing approaches that can support students, children and young people in schools very effectively. That is one of the reasons why some of the funding was targeted in a flexible way so schools could choose the mix of services that they needed. Schools look at their population and what the issues are and then choose the mix of services that will support their student population. It is important to have a broad-brush universal approach where everyone is committed to supporting children and young people. A range of other services should also be provided, whether they are universal or targeted. It is important to have a blend of services.

Previous questions asked what the most important protective factors were for children and young people, and I think the answer goes to your point, which is that one of the most important protective factors can be family—a family that cares for and nurtures their child. The family unit is important. A child having a friend and someone at school who knows them and cares about them is a really important factor, but we cannot overlook the fact that suicide is complex and touches many children from many different backgrounds. You cannot point the finger at any one thing and suggest, for example, that there could have been a family breakdown or the child did not have friends. We know those things are protective factors, but when it comes to suicide and self-harm it is much more complex than that.

The Hon. PAUL GREEN: Yes, and no-one is trying to take away from that. The evidence is pretty solid. The point is that these measures can all be written in the school policy and can be communicated but as my wife said the other day after reading a book on love languages, "It is one thing to tell your child that you love them; it is another thing for your child to know that you love them and feel that you love them." There are two different actions. We can put all these programs in our schools, but if we do not have individuals in the school taking the time out for these kids and sitting down with them to make them feel valued, all those other measures do not play the important part we were hoping they would.

Ms BALE: Indeed. That is why it is important that we recognise that we all have an important role to play. We should not underestimate that, regardless of the position we are in.

The Hon. PAUL GREEN: That is my point—someone does not need a degree to play that role.

Ms BALE: I agree with you.

The ACTING CHAIR: We have gone well over time. I thank you for your attention to detail. It has been valuable. I thank you for coming. You have indicated that you are taking some questions on notice. We look forward to receiving the responses to the additional material.

(The witnesses withdrew)

MURRAY WRIGHT, New South Wales Chief Psychiatrist, NSW Ministry of Health, sworn and examined

NIGEL LYONS, Deputy Secretary, Strategy and Resources, NSW Ministry of |Health, sworn and examined

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

Dr LYONS: I will. Thank you for the opportunity. I firstly acknowledge the traditional custodians of the land on which we meet today and pay my respects to elders past, present and emerging. I take the opportunity to acknowledge the heartfelt and deeply personal submissions that the Committee has heard from individuals and communities whose lives have been affected by suicide and suicide attempts. I also want to acknowledge the many organisations who are committed to preventing the suicide of our young people. NSW Health supports an evidence based, whole-of-community approach to suicide prevention and I acknowledge the pivotal role that NSW Health plays in ensuring that we reduce the number of deaths by suicide.

This financial year the New South Wales Government will invest $1.9 billion in mental health services. This expenditure directly supports the delivery of inpatient services and community mental health services, including those services for young people, and supports suicide prevention work, both directly and indirectly. To strengthen the coordination and integration of suicide prevention programs across the State, Health fosters strong partnerships with community managed organisations. With our consumer and carer organisations Health is committed to working with and alongside our key partners, particularly on suicide prevention programs. We have partnered with the Black Dog Institute and the LifeSpan program. You heard about that earlier. This system-based framework is the largest suicide prevention trial of its kind in Australia and is implementing nine evidence-based strategies across all local health districts in New South Wales.

Health is also working with the Commonwealth Government to implement the recently announced Fifth National Mental Health and Suicide Prevention Plan, which recognises the need for governments to work together to develop integrated whole-of-community approaches to suicide prevention. At a State level, we are working with the Mental Health Commission of NSW to develop the strategic framework for suicide prevention in New South Wales. The framework will bring agencies together to improve the planning, coordination and delivery of suicide prevention activities in New South Wales. The framework provides for collaboration with communities to test innovative models. This type of collaboration encourages local ownership of activities and builds capacity for community members to have an active role, as experienced by the New South Wales Our Healthy Clarence initiative.

As I am sure you are no doubt aware, the Clarence Valley is an isolated rural community that has had a higher than State average rate of suicide since early 2015. The community faced a challenging time with many expressing hopelessness, anger, despair and sadness. The Clarence Valley Council and the Northern NSW Local Health District worked together to develop a broad community mental health and wellbeing plan. The plan was launched in 2017 with 18 organisations, youth and community representatives collaborating to achieve the plan. Today we hear the feedback from young people in the community is that their community is healing, there is hope and opportunity, and our young people are being supported and engaged. I acknowledge that there are unique needs for particular communities and populations, including Aboriginal young people and young people without a family support network. NSW Health provides funding for priority populations through the New South Wales Suicide Prevention Fund and Lifeline services.

Also, all local health districts and specialty networks are implementing the NSW Youth Health Framework 2017-24. This work prioritises early intervention, targeted health responses for vulnerable young people and builds staff capacity to engage young people. We also work with Lifeline Australia to support their crisis support and suicide prevention services across New South Wales. The Government has committed $10.5 million over four years to Lifeline Australia through to 2018-19. Local health districts also provide around $400,000 per annum in direct funding to local Lifeline centres. There are a range of governance and accountability mechanisms relevant to mental health and suicide prevention. NSW Health has a rigorous and accountability-based approach to ensuring that all our healthcare organisations deliver on strategic priorities and comply with relevant policy directives. This is reflected in annual service agreements with sector partners as well as the NSW Health performance and purchasing frameworks.

In conclusion, suicide can occur in a wide range of situations. Individuals experience emotional and mental health crises in reaction to difficulties in family or personal relationships, to unemployment or to bullying at school, for example. A systems approach is crucial to reduce suicide and ensure that all people who are at risk of suicide receive effective care. The New South Wales Government has an ongoing commitment to reduce suicide and ensure that young people who are at risk of suicide receive the support they need. Under the current mental health reforms the government agencies are collaborating to implement the specific priority

actions to improve mental health and reduce suicide across the community. We are confident that the right path is in place for a coordinated system-wide approach across all levels of our community and supported with significant investment in place. This will ultimately deliver on the Government's commitment to improving the wellbeing of our communities and contribute to the reduction of suicide across New South Wales.

The ACTING CHAIR: I may regret asking this question, but what could we do better?

Dr LYONS: I think we are aware of the complexities and the need of not just a whole-of-government response but a whole-of-community response. I would have to say that the things that we are testing and trialling in a range of different places are all contributing to our learning about what we can do better. The challenge is about how we link all of that together, how we provide appropriate advice to people where they live about what services are available to them when they are in a time of need. I think the challenge is about how we get information from much of the data that we collect that gives us a holistic picture about what we can do differently and better. That is not just across government in New South Wales, but then across non-government organisations and community organisations working in this space. It is also around what happens in the services of health that are outside of what NSW Health offers. There is a huge amount that is provided by the Commonwealth, both in general practice primary care, but also in specialist services and private sector care, and linking all of that together is the challenge for us all.

The ACTING CHAIR: Cooperation between agencies and data collection appear to be the two key elements?

Dr LYONS: I would say that they were probably the two things that jump out for me. There is no doubt that we are learning a lot and there has been a lot of focus on the things that we can test and trial. It will be about ensuring that the things that we are doing show evidence of improvement, and that when they do that we actually scale those up—recognising though that many communities have particular contexts, not just their own context but how services are also provided in those environments that we need to take into account.

The ACTING CHAIR: Victoria and Queensland have a suicide register. Do you support that idea?

Dr LYONS: I think we review child deaths extensively here in New South Wales and it is something that could be undertaken by our current Child Death Review Team. I do not think there is a need for additional data collection, it is about using the data we have and ensuring that we are being appropriately informed and taking the next steps in strategies to address issues that are highlighted out of those reviews.

The ACTING CHAIR: The Committee has heard much evidence about programs delivered by healthspace and the Black Dog Institute. We have heard from Education about LifeSpan and safeTALK. Does the Department of Health evaluate those programs?

Dr LYONS: We are keen on evaluation of all of our work. When we do invest in new initiatives we do so on the basis they will be extensively evaluated for their impact.

The ACTING CHAIR: How does that evaluation work? Clearly, the best indicator at the end of the day will be a reduction in the suicide of young people. Other than that, what are the other indicators that the program is successful?

Dr LYONS: For each program—and this is one of the things we do for any newly trialled or tested approach—is to be very clear about what we are intending to achieve from that program, that project, and having that clarity at the start is really important. Secondly, we should agree on the sorts of things we can measure. They may be shorter term process measures, clinical outcomes or clinical care activities that will give us a sense that ultimately they will achieve the outcome. Sometimes the outcomes are longer term; they may be years down the track. What should we start to collect now that will give us a sense of whether or not this program will be effective? That is the quantitative side of things. There is usually also a qualitative side. That would involve some assessment of the individuals who have been through the program or project and asking about their experience or how they found it. In addition, we usually work with the health providers to ensure that what they are involved in is effective from their perspective. It involves the experience of the patient, the carer and the family, and also the experience of the providers. What is their experience of the project? Is it working?

The ACTING CHAIR: The Committee has heard that the suicide rate among males is higher than the rate among females. Despite that, the participation rate of young men in programs appears to be lower. What are we doing to get more young men to participate in programs that could make them disclose more about what they are feeling and what is going on in their lives? Are the current programs potentially delivering increased male participation?

Dr WRIGHT: The issue of males accessing mental health services and health services is across the lifespan, and it is not restricted to young men. It is not a recent phenomenon; it is longstanding. That is borne

out in the figures, which show that attempted suicide is higher among women than men, but completed suicide is significantly higher among young men. A number of the programs the Committee heard about from the Department of Education and other programs delivered by groups like the Black Dog Institute and beyondblue are trying, first, to reduce stigma. Shame and stigma are large barriers to young people accessing care, as they are to older people. Stigma is alive and well. It is a reflection of our culture and it is something we continue to battle.

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

Headspace is another example of a service addressing this issue. One of the drivers behind headspace has been to offer services that young people are more likely to access. Young people are not keen on authority figures and institutions. A lot of the shopfront activity undertaken by groups like headspace is designed to make the facility look like a place where a young person will not be intimidated. These issues are all important. This issue is not resolved, but many groups are trying to help people to have those conversations about their wellbeing and to talk to their friends. R U OK? Day is a good example of addressing the code of silence among males. If someone is struggling, the people around them try to talk about anything but. R U OK? tries to turn that on its head. There are initiatives, and most of them are just as relevant for young people.

Ms JODIE HARRISON: Your submission refers to key performance indicators [KPI]. I draw your attention to acute post-discharge community care and follow-up within seven days. How long has that KPI been in place? What is the performance in relation to 12- to 25-year-olds? How is that trending at the moment?

Dr LYONS: That KPI is part of the service agreements the ministry has with the local health districts. They are agreed annually and there is a focus on ensuring that the performance around a range of different areas is monitored over time. The KPI for post-discharge follow-up is an important component of the transition from acute care into the community space. It is monitored through reports from local health districts and speciality health networks, and it has been in place for a number of years. I do not have the age group breakdown, and I am not sure we collect it on a regular basis. However, I am happy to take the question on notice and see what information we can provide to the Committee.

The Hon. GREG DONNELLY: I have in front of me the New South Wales Government submission, which is marked submission No. 46. I refer you to page six, and particularly to paragraph 3.1.8. I am trying to grasp the dimension of suicide involving children and young people. Obviously there is data if a suicide proceeds and the child or young person is admitted to hospital. Is there any general formula or calculation to estimate how many children and young people attempt suicide beyond the data we have? A witness earlier today made a comment, but I would like your view as representatives of NSW Health because you obviously have access to very good information. I am trying to understand the dimension of the problem confronting us beyond the hard figures we have. What can we say about the likelihood of episodes of attempted suicide?

Dr LYONS: That is a very challenging question. There is no doubt that the information we have available is challenging. You have identified and highlighted some of the difficulties. We have better information about what is coded for inpatient admission, and that gives us a sense of the rates of self-harm and self-injury. However, when it comes to other places where young people seek care, it is much more challenging, particularly in emergency departments. They are complex and busy environments in which the reason for seeking care may not be disclosed. A person may present with an injury and the cause may not be obvious. It therefore may not be recorded as self-harm or self-injury. There is also a challenge with regard to what is recorded in other parts of the healthcare system. We must remember that many people will present to a general practitioner, an urgent care centre or a medical centre. There is no information in those environments that we have access to. So it is very difficult for us to get a picture of those rates. That is one of the challenges in moving towards more prevention strategies—having that information that might help inform us.

Dr WRIGHT: I agree with all of that. The other complexity is that not all self-harm is suicidal. A number of my colleagues would say that in fact in some cases people will self-harm in order to manage their emotional state. It is not something that is considered constructive. Initiatives like Project Air specifically try to help people develop alternative strategies. The measuring is extremely difficult. The identification by the

individual of what they were thinking at the time or what the purpose was at the time they involved in some self-harm is not always straightforward either.

The short answer is that the figures we collect have to be seen as an underestimate and as a not very reliable approximation of the extent of self-harm in the community. Differentiating the different kinds of self-harm is probably an important thing to try to do as well. I think we could improve the quality of the data that we do collect, and that is by people who are presenting to emergency departments. There are still avenues to improve on that and to better understand the connections between those presentations and things that happen afterwards, like retention, follow-up and things like that.

The Hon. GREG DONNELLY: If we look at the data and the research around suicide of children and young people in Australia, do you have a view about looking backwards—at what point can we say that the data and the research is starting to come to a satisfactorily high standard and quality to work forward from and see trends? In other words, can we reach back 20 years and say that that was when we started to get a decent picture, so we can look over a two-decade period or would you say it is much less than that? I am not trying to pin you down to a specific year. Can we only reach back 10 years and then from that point start to identify trends, patterns or whatever the case may be?

Dr WRIGHT: It is fair to say it is continuously improving, but I would think the data over the last 20 years is good enough to draw those kinds of comparisons. There was an enormous focus in the mid-1990s on concerns, particularly about suicide in young people. There have been serious attempts to improve the reliability and validity of the data since then. We can always improve this, but in terms of population-based trends and what I see as the great value of that information, which is to help guide policy development, it is certainly good enough to assist us in that area.

The Hon. PAUL GREEN: The Committee received evidence that overall governance of suicide prevention should sit with the Department of Premier and Cabinet [DPC] as effective prevention requires a whole-of-government approach—do you have a view on this?

Dr LYONS: The challenge for us in the governance of suicide prevention is that it is not just one level of government either, and it is not just government—it is the community as well. It is difficult to say where the best place is. Within Health we have certainly demonstrated that we believe it is an important role that we play. Increasingly, we are thinking not just about the response to people who need care in acute settings; it is about what we do outside of acute care. Increasingly, health promotion, disease prevention and illness prevention strategies are important from our perspective because it will prevent the need for care ultimately and provide a better life and greater wellbeing for individuals and communities.

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

Within Health, we are very keen to continue to take a leadership role and very keen to work with the Commonwealth. Increasingly, we are seeing that from the Commonwealth's perspective—the investment in suicide prevention activities, the fifth national mental health plan with a whole section on suicide prevention indicating the criticality of the Commonwealth and the nation taking a leadership role in that regard from a health perspective. We see Health as being a key leader and supporter of all those activities.

Within New South Wales, we are very keen to see the relationship built between what services we provide in NSW Health and the services that are provided outside. With the suicide prevention work that is going on with the primary health networks, we are very closely working with those primary health networks to identify service gaps and where we might work together to close those gaps and where we might work together to invest in better health care and prevention strategies that will minimise these adverse outcomes that we do not want to see.

The Hon. PAUL GREEN: What role does the department play in the fifth national mental health plan?

Dr LYONS: It was recently endorsed nationally—late last year. The phase we are now moving into is to ensure that there is alignment with the work we are doing in a range of different areas that complements and supports the implementation of the fifth national mental health plan. That assessment is under way at the moment. In particular, we are keen to ensure that there is alignment with our Living Well strategy, which is a 10-year strategy in New South Wales, and that where there is not complete alignment we adjust our approach to

ensure we are achieving the outcomes in the fifth national mental health plan. The Mental Health Commission of New South Wales will be actively involved, I am sure, in looking at performance, as will the National Mental Health Commission. We have had a discussion with the National Mental Health Commission about what sort of monitoring role they will play in ensuring that there is action on all of the indicators in that plan and that we are seeing progress on those performance measures.

The Hon. PAUL GREEN: Is it resourced appropriately to get the outcomes that you are talking about?

Dr LYONS: Certainly from the State perspective we are investing in additional resources in mental health every year and we have done as part of the Living Well reform. Each year, over and above the funds that have gone in to support growth in activity in our mental health services, there has been specific and targeted investment in particular areas of the Living Well reform, with a focus on what we can do around supporting more community based care, how we support specialist services for vulnerable groups and how we start to move toward more prevention strategies. That is our intention again with the 2018-19 budget, subject to what we receive for Health. We will be making a further investment to implement the Living Well reforms.

The Hon. WES FANG: The Committee received evidence on different approaches to talking about youth suicide. This is one of the questions I posed to Family and Community Services earlier. Can you outline what you consider to be an appropriate way to talk about suicide in the community, in schools and in the media?

Dr WRIGHT: I am sure you are familiar with some of the documents that have been put out by groups like Mindframe and the Hunter Institute of Mental Health. They pay a lot of attention and give a lot of advice to media organisations and others so that what we talk about actually elevates the discussion and improves the health of the community as opposed to raising issues that can inadvertently do harm. The advent of social media has changed that entirely. Twenty years ago the general practice was to talk as little as possible about particularly things like suicide, but social media bypassed that and particularly the young people were talking to each other about it whilst all the grown-ups were not doing so.

As I said in an earlier answer, I think the focus needs to be on wellbeing. I think you need to talk about being healthy and living healthy, and the role for both physical and mental health, active participation in community, the role of family and the role of community organisations. That is a kind of underpinning. Then it moves to the fact that stress is an inevitable part of life, and acknowledging that young people particularly face a lot of challenges which are stressful. The obvious stresses are school—the higher school certificate and the challenge of navigating the school yard—as well as dealing with stresses in their own families. We need to make it clear that in dealing with those challenges and experiencing stress—to a degree that you might want to discuss it with some other person—a student should feel free to discuss it with a counsellor, a teacher, a friend or a health professional.

One of the things that has been a key part of my professional life has been in trying to persuade people that you do not have to be 100 per cent sure that you have a mental health problem before you seek advice. A lot of people do not want to seek advice until they are really certain, and that causes delay. We try to encourage early intervention, but we also try to encourage people to show some curiosity about their friends and colleagues when they know that they are having difficult times. There is an awful lot you can say without destabilising people who are already vulnerable. There is some fairly straightforward advice that can be given. I know it gets given. That is part of the gatekeeper training that we hear so much about. A lot of it is very straightforward advice on what you can say during a conversation to provide someone with support without putting the situation further at risk.

The ACTING CHAIR: I see that it is five o'clock. I am grateful for your coming along this afternoon and giving us the benefit of your expert evidence. Are you prepared to answer any additional questions we might write to you about, seeking additional information?

Dr LYONS: Certainly.

Dr WRIGHT: Yes.

The ACTING CHAIR: That concludes the public hearing. I thank everyone for their participation today.

(The witnesses withdrew)

(The Committee adjourned at 17:02)