

ROYAL COMMISSION INTO VICTORIA'S MENTAL HEALTH SYSTEM

Melbourne Town Hall, Yarra Room,
90-130 Swanston Street,
Melbourne, Victoria

On Monday, 22 July 2019 at 10.00am

(Day 15)

Before: Ms Penny Armytage (Chair)
Professor Allan Fels AO
Dr Alex Cockram
Professor Bernadette McSherry

Counsel Assisting:
Ms Lisa Nichols QC
Ms Georgina Coghlan
Ms Fiona Batten

1 MS NICHOLS: Good morning, Commissioners. The Royal
2 Commission's terms of reference direct this Commission to
3 enquire into how most effectively to prevent suicide.
4

5 For the next two days the evidence will focus on
6 suicide prevention. Before I go on, it's important to
7 highlight the supports that are available. As the Chair
8 has said on earlier occasions, the Commission is very
9 conscious of the pain experienced by people who have
10 suicidal thoughts and those bereaved by suicide and is very
11 conscious of the courage of people coming to the Commission
12 and telling of their lived experiences.
13

14 If you are struggling or not okay, please seek help.
15 For those who are here with us at the Town Hall, there are
16 counsellors here who are available to sit and talk with you
17 in a safe space. For those who are joining us on the live
18 stream, there are telephone services available, including
19 Lifeline on 131 114, and Beyond Blue on 1300 224636.
20

21 The content of today's hearings may be challenging, so
22 please use the supports that are available.
23

24 Suicide is the leading cause of death for Australians
25 aged between 15-44. More people die by suicide and that on
26 our roads, and for every death by suicide, it is estimated
27 that as many as 30 people attempt to end their lives.
28

29 In Victoria, the suicide rate has not changed
30 substantially over the last 10 years. Victoria currently
31 has in place a policy framework that is consistent with
32 best practice.
33

34 In 2016, Victoria introduced the Victorian Suicide
35 Prevention Framework, its premise is that suicide is
36 preventable. It is informed by the World Health
37 Organisation's 2014 Suicide Prevention Report. The
38 framework has five objectives: build resilience, support
39 vulnerable people, care for the suicidal person, learn what
40 works best, and help local communities prevent suicide.
41

42 The challenges preventing Victoria are the same as
43 those facing other states and communities worldwide. You
44 will hear that suicide is a very complex problem and in any
45 individual case it can involve a multitude of risk factors,
46 some of which may have been present in a person's life for
47 many years and others of which act as catalysts in the

1 immediate term.

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1 is at the point of discharge from a clinical service after
2 a suicide attempt.

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4 In considering suicide prevention, it's also important
5 to consider the ripple effect that suicide has on family,
6 friends, colleagues, and the broader community.

7
8 It's estimated that, for every suicide, more than 135
9 people suffer intense grief or are otherwise affected. Of
10 course, no numbers are ever capable of conveying the
11 experience of losing a loved one. The numbers are cited,
12 however, because they're stark.

13
14 The evidence will show that, while there are some
15 shared experiences between those bereaved by suicide and
16 those bereaved by other modes of death, people bereaved by
17 suicide often have a unique and different experience.

18
19 People bereaved by suicide often say they feel guilty,
20 they feel like they have failed the person or let them
21 down; they question whether they have caused the death or
22 could have prevented it.

23
24 The evidence shows that suicide prevention strategies
25 need to be informed by the lived experience of those who
26 have had suicidal thoughts, who have suffered or have
27 survived a suicide attempt, family and friends caring for
28 people who are suicidal, and those bereaved by suicide.

29
30 The evidence to date has touched on suicide in a
31 multiplicity of ways, but in the next two days we will
32 concentrate further on this important topic.

33
34 We'll hear from five witnesses today. Mr Rod Jackson
35 will share his story of spiralling downwards after he lost
36 his job. Mr Jackson joined his local Men's Shed and will
37 explain the role that the Men's Shed played in his
38 recovery.

39
40 Victoria is the national leader in collecting data in
41 relation to suicide. The Coroners Prevention Unit of the
42 Coroners Court manages the Victorian Suicide Register. The
43 register contains detailed information on people who die by
44 suicide and the circumstances surrounding their death.

45
46 Mr Jeremy Dwyer, Manager Suicide, Mental Health and
47 General Investigations at the Coroners Prevention Unit will

1 give evidence today and explain the Victorian Suicide
2 Register and the implications of the information within it.

3
4 Professor Jane Pirkis is the Director of the Centre
5 for Mental Health in the Melbourne School of Population and
6 Global Health at the University of Melbourne. Professor
7 Pirkis researches the epidemiology of suicide. She will
8 discuss risk factors and the current state of the evidence
9 about the interventions that are likely to work.

10
11 Ms Susan Trotter is a community witness who will give
12 evidence under a pseudonym. Her evidence will not be live
13 streamed. Ms Trotter's son died by suicide. She will
14 share her story and her grief. She will give evidence in
15 the hope that no other parent has to experience what she
16 has experienced.

17
18 Mr Alan Woodward has worked in the field of suicide
19 prevention for 20 years and has experience in program
20 design, evaluations and research translation. One question
21 among others that his evidence will explore is what should
22 happen beyond trials. Victoria has made progress in
23 conducting a series of trials, but the challenge is to
24 translate the knowledge gained into improvements including
25 consistent care models that are made available right across
26 Victoria.

27
28 Ms Batten will call the first witness.

29
30 MS BATTEN: The first witness is Mr Rod Jackson. I call
31 Mr Jackson.

32
33 <RODERICK JOHN JACKSON, sworn and examined: [10.11am]

34
35 MS BATTEN: Q. Thanks Rod. Have you, with the
36 assistance of the Royal Commission's legal team, made a
37 witness statement for the Commission?

38 A. I have.

39
40 Q. I tender that statement. [WIT.0001.0042.0001] Rod,
41 could you please start by saying why you wanted to come and
42 give evidence today?

43 A. Yeah. My evidence today is to prevent someone else
44 going through what I have done, and try and put it out
45 there that there's more help, but not enough help, out
46 there for people considering what I went through from when
47 I lost my job back in 2009/2010.

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Q. Thank you. Can you please start at the point where you lost your job and tell the Commissioners your story of your mental health journey?

A. Yep. I lost my job back in 2009, and in August of that year I was spiralling down a never ending hole for quite a while. The problem was, I was left at home by myself from anywhere from 6 am to 6 pm every day for the week, when my wife, Jenny, and my son, Andrew, were at work, and my daughter, Rachel, was at school.

So, I had no-one to be with, no-one to talk to, and on this day that I did have my downfall I was - from what Jenny told me, I was writing abusive emails - I don't remember much - abusive emails to her. I was just spiralling out of control. From what I understand, she was gonna leave, and the next thing I know I am self-harming.

Then the next thing I know, I've got a knock at my front door, because the front door was unlocked, a policeman from the police station and two paramedics. On this day, they took me to a local hospital and in that local hospital, after getting there, they put me into a corridor with an open door to walk out and 500 metres down the road I could have stood on a train track and really self-harmed there. But there was something in my mind saying, "No, sit and wait".

I reckon I was in that corridor, it must have been for a short time but to me it felt like hours.

Jenny and my kids found me at the hospital in the Emergency Department rocking backwards and forwards. They asked us who my doctor was and they were pleased to know that my doctor was well known in mental health, he had done the mental health course, so I was very lucky there. I was put on medication and within the first week I had the local CAT Team come and visit me to make sure I wasn't self-harming again. I also had a couple of times I had a single person from the CAT Team come and look after me.

I found it very hard to walk into shopping centres. I found it very hard to do a lot of things. My wife had to reteach me to drive. To this day I still have some problems walking into shopping centres and crowds, but I'm a lot better at that now.

1 In late 2010 I got another job, I was able to get back
2 into the workforce. Once again, I got laid off there, but
3 because I was able to, I was able to get another job. But
4 before I was able to get back to work my wife had to sell
5 our family home because she did not know if I was going to
6 ever work again.

7
8 I have a really good doctor and I got to speak to a
9 counsellor at the time who told me that I should have had
10 this breakdown in my 20s. After moving to Sunbury, I had
11 lost a job again because of retrenchment. My wife Jenny
12 said to me, you're not staying at home, if you can't find a
13 job you're not staying at home, I don't want you going down
14 the same path as you did before.

15
16 So I joined our local Men's Shed. These guys are
17 brilliant. I'm sorry.

18
19 Q. You're fine, just take your time.

20 A. Our local Shed in Sunbury has a total of 92 members,
21 and I love all of them. When I joined the Men's Shed, I
22 actually ended up on Who Wants to Be a Millionaire. We
23 were able to win some money, a good amount of money, on
24 that program to buy us another house in Sunbury.

25
26 Two of my mates from there came and gave me a hand
27 were renovation of the kitchen. As we were pulling the
28 kitchen out, it was all termite damaged. The second night
29 we were doing it, I was having tea with my wife and
30 daughter, and my daughter and I had an argument and she
31 stormed out of the house and I started to self-harm again.

32
33 Jen called the police, they came, as well as the
34 paramedics. By the time they took me in the ambulance I
35 was a feeling a lot better, but at the same time I was
36 still agitated. What happened in the ambulance was, I was
37 talking to the paramedic in the back.

38
39 When I was 16 I started at Trans Australia Airlines in
40 the engineering department - hated it. But the girl that
41 was a paramedic in the back of the van, funny enough, I
42 knew her father because her father was a year above me as
43 an apprentice at Trans Australian Airlines. When I heard
44 that, I started to calm down again from my agitation.

45
46 The next day after leaving the hospital, I was only
47 there for a couple of hours speaking to the CAT Team. When

1 I was home Jenny had rung. At that stage the President of
2 the Men's Shed, Dida Jetovic who came and said, "Come on
3 Rod, we're going for a walk, it's the best thing for it."
4 So, he and I went for a walk for an hour. He helped me a
5 lot that day but there is another person the next day when
6 I was at the Shed, I even got a phone call from him before
7 I went, and I thank him more than any other and that's Gary
8 Peddit. Gary took me for a cup of coffee. I sat with him
9 for about an hour and cried my eyes out. He's one of the
10 ones that understands what mental health is like.

11
12 At our shed a couple of years ago now I was at the
13 cluster meeting at Caroline Springs through the Victorian
14 Men's Shed Association. I stood up and spoke about my
15 mental health. I will stand up in front of anybody and
16 tell exactly word-for-word what happened to me and what the
17 Men's Sheds are about.

18
19 The first thing I say at any time I stand up at any
20 community group or people who want to listen, I say, "Look
21 at the person to the left or right of you". You know, you
22 get funny sayings like, "Oh, he's going bald or he's got
23 four eyes or whatever", and I go, "Now have a look at me"
24 and they all look. And I say, "Well I've got an illness
25 that you can't so see. I battle it every day." And they
26 go, "Ah yeah but" and I said, "No, I battle with a mental
27 health condition, a mental health illness." And the looks
28 I get are, wow.

29
30 When I'm at these meetings I still get people coming
31 up to me and saying, "Thank you for talking about it."
32 Last year the Victorian Seniors Magazine came to our Shed,
33 or it was earlier this year, and filmed to do with people
34 in retirement to do with our Shed. The president of our
35 Shed spoke on the video and explained what it's all about,
36 and he said in that video that, one of the guys, it was at
37 a Christmas party, one of the guys stood up and said, "I'd
38 like to thank the Men's Shed for saving my life."

39
40 Two weeks ago when I was at the Shed I told them what
41 I was doing here and I got the same, and I said the same,
42 if it wasn't for the Men's Shed that I belong to, I don't
43 know where I'd be today. I have a good counsellor that
44 belongs to the Sunbury Community Health, and this is why I
45 love the Shed.

46
47 I have a good counsellor that belongs to the Sunbury

1 Community Health. This is why I love the Shed. A good
2 friend of mine who's in a wheelchair happened to come along
3 to the community health, and I wasn't feeling well, and he
4 didn't know this. He asked me to fix his phone. He had a
5 problem with his phone, so I said, "Look mate", and my
6 counsellor actually walked out and I said, "Look mate, I've
7 gotta go." My counsellor turned round, because she knew
8 him as well, she said, "No, you fix the phone, Rod, it'll
9 be alright." As I'm fixing the phone he's gone to her and
10 said, "I can see Rod's not well, he needs to talk to you."
11

12 Now, these guys at the Shed aren't psychologists,
13 aren't community, they're all just blokes that have been in
14 industry, office works, teachers. At our Shed, I know of
15 at least eight that suffer from mental illness, and my mate
16 [REDACTED] does as well. He looked into my eyes and
17 he could tell that I wasn't there. This is last Christmas.
18 The doctor I've got is a great doctor: as soon as I spoke
19 to him, he said, "Okay, we're going to have to increase
20 your medication." And I said, "Fine." Speaking to my
21 counsellor, she said, "Make sure you speak to your doctor."
22 Which I did.
23

24 At our Shed in Sunbury, we do a lot of things to help
25 each other. I'm with a couple of guys to do with welfare.
26 We don't broadcast it with welfare, neither do the other
27 two guys. But one of them, if someone's sick, one of them,
28 his wife, knits hospital socks for the people that are
29 going into hospital.
30

31 I got asked about a month and a half, two months ago,
32 "Oh Rod, can you go see one of the members?" And I said,
33 "Why?" He said, "He wants to end his life." And I've
34 gone, "What?" So I went out and spoke to him and we got
35 another member, I call him "the doc". He and I spoke to
36 this member and asked what his problem was. He was fed up
37 with the noise in his ears to the point where he wanted to
38 not be here any more.
39

40 We stood there and listened to him. We gave him some
41 advise, the doc said, "Have you seen a specialist about
42 your hearing?" And he goes, "No." We said, "Look, you
43 never know, if you see this person, you never know, they
44 may help and he's gone, "Oh I'll give it a go." We also
45 said, "Try the radio on the AM band." He goes, "Why, I
46 can't sleep with music." We said, "No, if you use the
47 white noise from the radio, it can interact with the

1 tinnitus, the ringing in the ears, and may be able to get
2 you to sleep properly." Three weeks later I saw this guy
3 at the Shed and I went up to him and I said, "How are you
4 going, are you okay?" He turned around and said to me,
5 "Rod, if it wasn't for you, I don't think I'd be here."
6

7 He said, "Even down to" - his partner said to him,
8 "You're being selfish, if you want to hurt yourself, you're
9 being selfish." So, when he spoke to me about that, I said
10 to him, if they're saying that, you know someone loves you
11 because they don't wanna lose you like the way we don't
12 wanna lose you from the Shed.
13

14 The hardest part with all the mental illness, it's not
15 the pressure on yourself, it's the pressure that's put on
16 to your wife, or your husband, and your children. I was
17 being selfish that day. Even to this day I still say to my
18 wife, "I'm sorry", because it's so hard. People just don't
19 realise how hard it is. That's why the Victorian Men's
20 Shed Association have got all these Men's Sheds. There's
21 over 300 Sheds in Victoria, and in those Sheds is a person
22 like me, and we look after each other.
23

24 We know funding is hard. We do a lot for the
25 community out of our Shed to raise money so that we can
26 keep everybody going at our Shed, so they can come and have
27 a cup of coffee and talk; you'd be surprised what we talk
28 about down there. We talk anything from the football to
29 prostate cancer.
30

31 I have learnt so much about prostate cancer over the
32 last four years because I've had four of my friends
33 diagnosed with prostate cancer. 90 per cent of the blokes
34 that come into the Shed, all they're looking for is
35 friendship as well as companionship, because their wives
36 are at work still possibly, or their wives are going off to
37 Probus or meetings, or they're playing bowls or they're in
38 their walking groups and the guys don't wanna do that, so
39 they sit at home twiddling their thumbs going mad. The
40 Men's Sheds are a lifeline for those guys.
41

42 When I was speaking to Eddie on Who Wants to Be a
43 Millionaire, he said, "What happened?" And I said, my
44 passion is mental illness, not because I want to study it,
45 it's because I have it. I mentioned about a great place
46 for men to go to on the television programme which is the
47 Men's Sheds, go find your local Men's Sheds and go talk.

1
2 The week after it aired I was at the Working With Wood
3 Show and there was a guy from the Australian Mens
4 Association spotted me, and he said, "You gave us the best
5 advertisement you could ever think of." He turned around
6 and said, "Thank you" because he knows how many men survive
7 because of Men's Sheds.
8

9 From what I have read and what I understand, at least
10 six men a day commit suicide. A lot more self-harm like I
11 did, twice. We've just got to get the word out there that
12 this is help for all of us in many ways: a good counsellor,
13 someone to talk to over a cup of coffee, and your local
14 Shed for all men. Just to go down, if they don't want to
15 be a member, they can come down three times to have a cup
16 of coffee and have a look. If people do that, they
17 actually end up staying for the next 10 to 15 years.
18

19 That's why I look at what I'm doing today to help
20 every one of them. If I can save one person's life because
21 of this, you've made my day.
22

23 MS BATTEN: Thank you very much, Rod. Chair, are there any
24 further questions for Rod Jackson?
25

26 CHAIR: No. Thank you very much, Mr Jackson, for coming
27 and sharing your journey with us and for being such a
28 strong advocate on behalf of Men's Sheds.
29

30 MS BATTEN: Thank you. May Mr Jackson please be excused?
31

32 CHAIR: Yes. Thank you very much.
33

34 <THE WITNESS WITHDREW
35

36 MS NICHOLS: The next witness is Mr Jeremy Dwyer. I call
37 him now.
38

39 <JEREMY ANDREW DWYER, affirmed and examined: [10.33am]
40

41 MS NICHOLS: Q. Mr Dwyer, are you the manager, Suicide
42 Mental Health and General Investigations with the Coroners
43 Prevention Unit at the Coroners Court of Victoria?
44

45 A. Yes, I am.
46

47 Q. Are you responsible for coordinating the staff who
maintain the Victorian Suicide Register?

1 A. Yes.

2

3 Q. Have you prepared a statement and a report about
4 suicide and mental-ill Health in Metropolitan Melbourne and
5 in Regional Victoria?

6 A. Yes, I have.

7

8 Q. I tender that statement with the attached report.
9 [WIT.0002.0019.0001] Mr Dwyer, what's the Coroners
10 Prevention Unit within the Coroners Court of Victoria?

11 A. The Coroners Prevention Unit is a specialist unit
12 within the court that assists Coroners with their
13 investigations into external cause deaths, particularly
14 preventable deaths, and provides evidence and material and
15 advice on opportunities to prevent these deaths, as well as
16 maintaining a range of databases to develop the evidence
17 base further to identify opportunities for prevention.

18

19 Q. What's the Victorian Suicide Register?

20 A. The Victorian Suicide Register is a database that we
21 designed in 2011 and 2012, then implemented to store
22 detailed information on suicides investigated by Victoria's
23 Coroners in order to improve our understanding of suicide
24 and assist Coroners in identifying opportunities for
25 interventions to reduce suicide in Victoria.

26

27 Q. Is it the most accurate and timely source of detailed
28 information on suicide in Victoria?

29 A. I believe that it is. In terms of timeliness, we run
30 what's called prospective surveillance on all deaths
31 reported to the Victorian Coroner, and under the Act a
32 suspected suicide is required to be reported. So a
33 prospective surveillance program is that we will look at
34 all deaths that are reported every day and will identify
35 suspected suicides among them and add them to the Suicide
36 Register as they occur. We've gone back and looked at the
37 accuracy of our identification over time, and between
38 initial identification and final confirmation from Coronial
39 investigation, we're between 96 and 98 per cent accurate.

40

41 Q. One of the things you've said in your statement is
42 that the dataset in the register is maintained
43 prospectively, meaning that the suicides are monitored in
44 near real-time?

45 A. That's correct.

46

47 Q. Can you tell the Commissioners what you mean by that?

1 A. As I just explained --

2

3 Q. I might just ask you to slow down a little bit, and
4 also speak a little closer to the microphone so we can hear
5 you.

6 A. Apologies.

7

8 Q. No problem. So, maintaining the dataset prospectively
9 and monitoring suspected suicides in near real-time; can
10 you explain what is meant by that?

11 A. So, in terms of prospective surveillance, maintaining
12 the data prospectively, we will add new suspected suicides
13 to the database on a daily basis and we'll add certain
14 information including sex, age, location of usual
15 residence, location of fatal incident, method and so on, so
16 that we can get an idea of what's happening with suicide as
17 it occurs in Victoria.

18

19 We use that information for a range of different
20 purposes. At the moment we're in collaboration with the
21 Department of Human Health and Services to assist their
22 place-based suicide prevention trials, and so, that
23 information when requested by the department will be
24 provided to them.

25

26 We provide reports and sort of weekly or fortnightly
27 updates looking at where there are areas of unusual suicide
28 activity to alert the DHHS if they want to look at it
29 further and the Department of Health and Human Services
30 staff who run the suicide prevention program there will
31 also make enquiries of us and will assist them to
32 understand what's going on if they have any concerns.

33

34 Q. I might just stop you there and take you back a little
35 bit. Let's focus on what the Suicide Register contains.

36 So, does it have two datasets starting with a core dataset?

37 A. That's right.

38

39 Q. Just explain in simple terms, maybe slowing down
40 again, what the core dataset covers?

41 A. The core dataset includes basic information about
42 deaths reported to and investigated by Victorian Coroners.
43 So, it includes, for example, sex and age of the deceased,
44 location where the suspected suicide occurred, the location
45 where the person usually resided, and the suicide method
46 and, when it's confirmed, the Coronial cause of death.

47

1 Q. And the enhanced dataset, what's addressed in that?
2 A. The enhanced dataset includes a range of more detailed
3 information that is coded when the Coroner's investigation
4 has proceeded to a point where we have, for example,
5 witness statements and medical records and so on.

6
7 It includes socio-demographic information about the
8 deceased which we will often not know at the point where
9 the death is first reported. It will include information
10 on stressors that they may have experienced, diagnosed and
11 suspected mental illness, contacts with health services for
12 treatment of mental illness, familial stressors and
13 interpersonal stressors, post-mortem toxicology, a whole
14 range of information, about 240 variables.

15
16 Q. Broadly speaking, how is that information gathered for
17 the purposes of putting it into the enhanced dataset?

18 A. We have trained coders who review the full Coronial
19 brief and all of the material that's gathered for the
20 Coroner's investigation and those coders will then enter
21 the information, and we have a coding and quality manual, a
22 quality process and so on to support that to ensure that
23 the best possible and most accurate and complete
24 information is entered.

25
26 Q. From an overarching perspective, what's the purpose of
27 the maintenance of the Victorian Suicide Register?

28 A. Its primary purpose, the purpose for which it was
29 first developed, was to assist Coroners with their
30 investigations into suicide deaths, to answer questions for
31 Coroners about the circumstances in which suicides occur
32 and what opportunities there are for interventions. But
33 other purposes have developed over time as well.

34
35 Q. Such as?

36 A. For example, I mentioned before that we provide
37 information to support the place-based suicide prevention
38 trials. We also collaborate with a number of academics,
39 because the data is seen to have academic value as well, so
40 we'll engage with relevant experts, some of which I believe
41 we'll be hearing from today, about suicide, the
42 interpretation of the data and generating new insights into
43 suicide that will hopefully lead to prevention.

44
45 Q. Are there any noteworthy limitations on the data held
46 within the Victorian Suicide Register?

47 A. Well, first, it needs to be recognised that we code

1 the material that's gathered for the Coroner's
2 investigation; we don't go out and speak to family members
3 and police, and medical practitioners and so on
4 independently of the Coroner's investigation. So, the
5 Suicide Register reflects the material that was gathered
6 for the Coroner's investigation and different Coroners may
7 have a different focus from death to death in their
8 investigations.

9
10 Q. You mentioned in your statement that the Coroner's
11 Prevention Unit is working with DHHS and other partners on
12 a data linking project to understand how people who die by
13 suicide engage with public mental health services. Can you
14 tell the Commissioners a bit about what that project is and
15 what its purpose is?

16 A. I can describe it in quite general terms, but I should
17 emphasise that the project is a DHHS funded and auspiced
18 project, and our role in it really is the provision of
19 data.

20
21 So what we've done is, we've provided 10 years of data
22 to the Department of Health and Human Services to be linked
23 with other datasets that they hold through the Victorian
24 Centre for Data Linkage and for that data to be analysed to
25 look at what types of public mental health services are
26 being accessed by people in the 12 months leading up to
27 their suicides. My understanding is that the data is still
28 being analysed, and so, I don't know what the results of
29 that are.

30
31 Q. I see. Can I ask you, moving from the register
32 itself, for the purposes of it, how are suicide rates
33 calculated?

34 A. So, the suicide rate, the reason why we're interested
35 in rates is because you have your frequency of suicides, so
36 the number of suicides that occur, and then you have for
37 each person who suicides, they belong to different
38 populations: by age, by sex, by their national identity, as
39 Aboriginal and Torres Strait Islander people and so on.
40 So, the reason why you look at rates, what the rate is
41 basically is the frequency of suicides in a particular
42 group divided by the population who belong to that group.
43 The reason why we look at rates is so that we can see where
44 there's a greater frequency of suicides occurring within
45 particular populations.

46
47 Q. Are frequencies of less than 20 generally considered

1 unreliable where that is the frequency for a given
2 population group?

3 A. Generally, but I should emphasise that I don't have a
4 background in statistics or epidemiology.

5

6 Q. But that's the operating principle as far as you stand
7 for the Victorian Suicide Register?

8 A. Yes, that's correct.

9

10 Q. Does the Coroners Court prefer to use average annual
11 rates when examining suicide rates by sex and age group?

12 A. Yes.

13

14 Q. Why is that?

15 A. When you get down to looking at suicides by sex and by
16 age group, by year, you have a whole lot of frequencies
17 that are in absolute terms quite small, and also you've got
18 a substantial amount of fluctuation from year-to-year, so
19 average annual rates help you to understand what the
20 underlying patterns are over time.

21

22 Q. Thank you. For the purposes of location-based suicide
23 analysis, does the register record the location where the
24 incident occurred and the location where the deceased
25 usually resided?

26 A. That's correct.

27

28 Q. Are they relevant for different purposes?

29 A. Yes. So, the location where the incident occurred can
30 assist. I mean, there are a whole lot of different
31 interventions for suicide, universal and specific
32 interventions and so on, and some of those interventions
33 require you to understand where a suicide occurred; others
34 of those interventions are more about understanding where
35 people usually lived, what types of services they may have
36 had access to, how remote they were from health and other
37 services and so on.

38

39 Q. How is mental illness defined for the purposes of the
40 Victorian Suicide Register?

41 A. We code two different sets of data on mental
42 ill-health: we code where we have evidence of diagnosed
43 mental illness according to the ICD-10, and that is where
44 the material that's been gathered for the Coroners
45 investigation indicates that the person had a formal
46 diagnosis from an appropriate health practitioner.

47

1 But also, there's a number of suicides where there's
2 no evidence of formal diagnosis, but we have, for example,
3 doctor notes saying they had traits of a particular mental
4 illness or so on, or we have family members saying that the
5 person suffered or experienced mental ill-health. However,
6 we don't have any direct evidence from a doctor, and so
7 we'll code those as suspected mental illness because we
8 want to know about those but we don't have formal evidence
9 that we would accept.

10
11 Q. Does the Victorian Suicide Register include coded
12 information on health service contacts for mental
13 health-related issues within both six weeks of death and
14 12 months of death?

15 A. That's correct, yes.

16
17 Q. Does the Coroners Court hold data about the presence
18 of mental ill-health in cases where the deceased has died
19 by means other than suicide?

20 A. We do hold that information in some datasets that were
21 put together for some projects. For example, we have that
22 information for some overdose deaths and family
23 violence-related deaths.

24
25 Q. The Royal Commission has sought information on suicide
26 frequencies and rates across a number of domains, including
27 age groups, sex, location of usual residence, be it
28 Metropolitan Melbourne or Regional Victoria, the presence
29 of diagnosed mental ill-health and whether the deceased
30 were Aboriginal and Torres Strait Islander people. You
31 have kindly responded to that request both in your detailed
32 report and in a PowerPoint presentation. Can I ask that
33 you speak to the PowerPoint presentation? We will get that
34 up and running now. [VFH.0019.0001.0004]

35
36 I should have asked you, you probably can't control it
37 from where you are, can you?

38 A. I don't believe so.

39
40 Q. Perhaps we can ask for the next slide to be shown when
41 you're ready, thanks, Mr Dwyer.

42 A. Okay, thank you. I'm really sorry, I should have done
43 this at the beginning. I acknowledge the country on which
44 we're meeting today, the Kulin Nations, and pay respects to
45 any Elders past, present and emerging. And, thank you very
46 much for inviting me to appear before the Royal Commission
47 today.

1
2 I used, as you've heard, the Victorian Suicide
3 Register to produce a data summary setting out basic
4 information on suicide in the state of Victoria. The
5 summary itself is quite lengthy and it's full of data
6 tables, the significance of which is not always immediately
7 apparent.

8
9 So, I was asked to assist the Royal Commission by
10 preparing a brief overview in PowerPoint form. There are
11 11 slides and I promise they won't take more than about
12 8 minutes.

13
14 Q. Mr Dwyer, you just take your time, you can relax,
15 we've got plenty of time today, so just keep going.

16 A. With your leave, I'm happy to. Who's controlling,
17 sorry?

18
19 Q. Over here.

20 A. Next slide, please. The annual frequency of suicides
21 in Victoria which is the blue line in this graph, was
22 relatively stable at around 550 per year between 2001 and
23 2010, but in more recent years the frequency's been
24 steadily rising and it reached 720 suicides in suspected
25 and Coroner determined suicides last year.

26
27 Furthermore, we believe this increasing trend is
28 continuing this year. As I've already discussed, we run
29 surveillance to identify suspected suicides on a daily
30 basis, and to media, we've identified 368 probable suicides
31 in the first half of 2019. So its likely projecting that
32 we'll be at around 740, give or take 20 or so, by the end
33 of this year. So, it's a substantial public health issue.

34
35 While the annual frequency of Victorian suicides is
36 trending up, so is the Victorian population, and that is
37 shown in the orange bar graph below the blue line. This is
38 the population of people aged 10 years and above. So, this
39 needs to be accounted for in considering what the increased
40 frequency means: do we have more suicides because we have
41 more people living in Victoria, to put it crudely?

42
43 The way we do this is by calculating the suicide rate.
44 At its most basic or crude level the suicide rate is
45 calculated by dividing the number of suicides each year by
46 the population of Victoria in that year.

1 If I have the next slide, please. What we see, this
2 graph shows the annual crude suicide rate per 100,000
3 Victorians aged 10 years or over per year. It's been
4 relatively steady, suggesting the increasing trend in
5 suicide frequency is following the increasing Victorian
6 population.

7
8 Can I have the next slide, please. If I move now from
9 all Victoria to looking at suicide within geographical
10 regions that are identified as being of interest to the
11 Royal Commission, these are Metropolitan Melbourne and
12 Regional Victoria.

13
14 We see around two-thirds of Victorian suicides
15 each year occur in Metropolitan Melbourne, which is shown
16 by the blue line on the left-hand of the two graphs, and
17 the remaining third occur in Regional Victoria. This 2:1
18 ratio has been quite consistent over the last 10 years.

19
20 But while twice as many suicides occur in Metropolitan
21 Melbourne as Regional Victoria, the population of Regional
22 Victoria - so the populations again are orange bars - is
23 far smaller than Metropolitan Melbourne.

24
25 So, when we move from frequencies to rates, what we
26 find is - with the next slide - that the annual suicide
27 rate per 100,000 residents is about 50 per cent higher
28 each year in Regional Victoria than Metropolitan Melbourne.

29
30 Then you get further insight into this difference
31 between suicide rates if we consider sex and age group in
32 the next slide. These graphs show the average annual
33 suicide rate among men, which is the blue lines, and women
34 the orange lines, by age group along the horizontal axis in
35 Metropolitan Melbourne and Regional Victoria.

36
37 The first notable finding is that suicide rates among
38 women are lower than among men in both Metropolitan
39 Melbourne and Regional Victoria. This is a reflection of
40 the fact that in Victoria, as in all other Australian
41 states and many other countries, a lot more men than women
42 die by suicide each year. Around 75 per cent of Victorian
43 suicide deceased are males and this has been the case for
44 at least 15 or 20 years.

45
46 The second notable finding is how suicide rates differ
47 by age and sex. The suicide rate for women is lowest in

1 the youngest age groups, rises to a peak in ages 45 to 54
2 then declines thereafter. For men, the lowest suicide rate
3 is also among the youngest age groups and then the rate
4 rises to a peak in ages 35-55 before declining, but then
5 with a second peak reached among the oldest age groups.
6

7 The third notable finding is the magnitude of the
8 difference in suicide rate by age among males in
9 Metropolitan Melbourne, versus Regional Victoria. While in
10 both locations a peak suicide rate is reached in those aged
11 around 35-55, this peak in Regional Victoria is nearly
12 double that in Metropolitan Melbourne. Likewise for the
13 second peak in the oldest, it's far higher in Regional
14 Victoria.
15

16 Can I have the next slide, thanks? I've been talking
17 here, and I'm going to continue talking about Metropolitan
18 Melbourne verse Regional Victoria, but it's also really
19 important to note, as this slide demonstrates, that there's
20 enormous variation in suicide frequencies and suicide rates
21 within Metropolitan Melbourne and within Regional Victoria.
22

23 This shows a selection of local government areas in
24 Metropolitan Melbourne and in Regional Victoria, their
25 suicide frequencies, which is an orange bar, and the
26 suicide rate which is shown by the blue line, from local
27 government area to local government area, and you can see
28 how great the variation is. My purpose in showing this was
29 just to emphasise that, when you're looking at suicide and
30 discussing it across Metropolitan Melbourne and Regional
31 Victoria, but getting even more local than that is an
32 important part of understanding what's going on in
33 Victoria.
34

35 Next slide. I just want to move on to consider some
36 basic data on the intersection between suicide, mental
37 ill-health and the Victorian health system, which I think
38 is the material that's hopefully of greatest relevance to
39 the Royal Commission.
40

41 Starting off with the proportion of Victorian suicide
42 deceased who experience diagnosed and suspected mental
43 illness and for whom we had no evidence of either diagnosed
44 or suspected mental illness.
45

46 This bar graph, the dark blue shows the proportion of
47 suicide deceased who had a diagnosed mental illness. The

1 orange shows those who had suspected mental illness, and
2 the grey at the top is the proportion of deceased who had
3 neither diagnosed nor suspected mental illness.
4

5 What it shows is that there's a high proportion of
6 people who resided in Metropolitan Melbourne than Regional
7 Victoria who had a mental ill-health diagnosis, and there
8 was also a greater prevalence of suspected mental illness
9 among those who resided in Regional Victoria. And higher
10 also of course, by sex, a higher proportion of females than
11 males had a diagnosed mental illness.
12

13 There are at least two possible explanations for this
14 geographic finding. The first is that mental ill-health
15 was less prevalent among people who died by suicide and
16 resided in Regional Victoria. That's, I think, considered
17 to be an unlikely explanation.
18

19 The second is that perhaps people in Regional Victoria
20 faced more challenges in accessing mental health services
21 and getting a mental health diagnosis in the first place
22 and so the final slides I want to present address that
23 possibility. Slide 9, thanks.
24

25 These graphs show the proportion of people who had
26 contact with a health service for mental health-related
27 issues in the 12 months leading up to suicide during the
28 period 2009-2015 in Victoria.
29

30 About 60 per cent of deceased had contact with a
31 health service for mental health related issues. Women had
32 higher levels of contact than men, and people residing in
33 Metropolitan Melbourne had higher levels of contact than
34 people residing in Regional Victoria.
35

36 Of particular note, if we look at the next slide
37 thanks, when we look in more detail at the types of health
38 services that were involved, contact with specialist mental
39 health services, for example, psychiatrists, psychologists,
40 CAT teams, was lower in Regional Victoria than Metropolitan
41 Melbourne, and much lower for Regional Victorian men who
42 are the group with the highest suicide rates.
43

44 Next slide, please. This shows the same data except
45 for health service contact within six weeks, so immediately
46 proximal to death. Across all groups, just over
47 50 per cent of people had contact with the health system

1 for mental health related issues in the six weeks preceding
2 suicide, and again we have the same pattern with respect to
3 sex and location of usual residence: higher proportion of
4 contact among women, high proportion of contact in
5 Metropolitan Melbourne.
6

7 And, the final slide. And again, the same pattern
8 with respect to engagement with specific types of health
9 services. This is sort of the final summary slide, and
10 even from this very basic data, there are a number of
11 issues and observations I think and, if you are happy for
12 me to do so, I have just a couple of concluding
13 observations.
14

15 Q. Absolutely.

16 A. First, around 50 per cent of people who suicided in
17 Victoria between 2009 and 2015 had contact with health
18 services for mental health related issues in the six weeks
19 leading up to their death. I don't know whether experts
20 would consider this to be a high or low proportion, but
21 regardless, if 50 per cent of those who suicided were known
22 to the health system within six weeks of their death, I
23 think it means that any improvements in mental health
24 services that emerge from the Royal Commission's findings
25 have real potential to reduce suicide.
26

27 Second, according to this data general practitioners
28 in the health service are most frequently involved in
29 mental health care of Victorians within 12 months and
30 within six weeks of suicide. This is consistent with what
31 we see assisting Coroners with individual suicide death
32 investigations: the specialist mental health services
33 provide advice and guidance and then the general
34 practitioners implement this advice and guidance on a
35 day-to-day basis in working with the patient.
36

37 I understand that general practitioners are sometimes
38 not thought of in discussions around Victoria's mental
39 illness system. The term is often used to describe the
40 specialist mental health services, but clearly, they're
41 crucial to the functioning of the system.
42

43 The third point is, most people who have contact with
44 health service within 12 months or within six weeks of
45 their suicide in Victoria actually, they had contact with
46 multiple health services, which is why the numbers here sum
47 up to far greater than the overall totals.

1
2 The need for better coordination of care and
3 communication between clinicians and health services is a
4 recurring theme in Victorian Coroners recommendations that
5 were included as part of acting State Coroner Caitlin
6 English's submission to the Royal Commission.
7

8 Q. Thank you very much Mr Dwyer. Can I just ask you one
9 question, and that is, what are the challenges involved in
10 identifying at a more granular level those cohorts within
11 the Victorian population who are at high risk of suicide?

12 A. That's an incredibly broad question. So, the question
13 that comes out of it, this is just sort of basic
14 information about suicide in Victoria, but what people
15 really want to know is among all of these, are there
16 particular groups, say particular cultural and
17 linguistically diverse groups, or are there particular
18 cohorts defined in a number of different ways who are at
19 higher risk of suicide? And, we have two challenges in
20 identifying those groups or calculating rates to say, yes,
21 this group is at increased risk or, no, this group is not.
22

23 The first is in actually identifying relevant suicides
24 that are of interest when we are looking at a question. If
25 I could speak to that perhaps with respect to Chapter 6 of
26 the data summary that I provided about suicide among
27 members of the Aboriginal and Torres Strait Islander
28 community in Victoria?
29

30 The core is extremely - you know, there's a big focus
31 in the court on working with the Aboriginal and Torres
32 Strait Islander community and assisting the community with
33 engagement with the court. Historically what we've found
34 when we've looked at data when we've tried to identify
35 Aboriginal and Torres Strait Islander people among suicides
36 that have occurred in Victoria, is that, we've got a number
37 of different data systems where we might be able to find
38 out that someone is an Aboriginal and Torres Strait
39 Islander person, but the data systems or the data sources
40 are each unreliable when compared to one another.
41

42 So, for example, we'll have police attending who will
43 fill out an initial report of death to the Coroner, and
44 then we'll be speaking to families or undertakers will be
45 speaking to families and they will get different
46 information on whether the person was an Aboriginal and
47 Torres Strait Islander person or so on; then we'll have

1 material in Coronial briefs that indicates again that maybe
2 inconsistent with what else we've been told that indicates
3 they may be an Aboriginal and Torres Strait Islander
4 person.

5
6 And so, what we've known from this is that our
7 identification of Aboriginal and Torres Strait Islander
8 deceased people among suicide deceased in Victoria has
9 historically been likely to be a substantial
10 under-reporting.

11
12 And, as part of the court's efforts to address this
13 and to work more closely with the Aboriginal and Torres
14 Strait Islander communities in Victoria, earlier this year
15 we had an Aboriginal Family Engagement Coordinator position
16 appointed to the court.

17
18 Now, since he has started tragically - so, his role is
19 to work with affected communities to liaise with Aboriginal
20 and Torres Strait Islander communities and be a conduit for
21 information through the court, and as a result of the
22 position we've been getting, we believe, much better
23 identification of Aboriginal and Torres Strait Islander
24 people among deceased reported to the court, and tragically
25 it appears, based on what we know even for the first
26 six months of this year, that our historical underestimate
27 has been quite substantial.

28
29 But the issue there is sort of repeated in a number of
30 other contexts when you're talking about the identity of
31 people. A really good example is in the gay/lesbian, queer
32 intersex, LGBTIQ community. We know a certain number of
33 suicides of people who would identify as belonging to that
34 community, but we suspect that we're missing out on at
35 least some and potentially quite a lot, because we just
36 don't have the data and the evidence, it's just not
37 gathered in the investigation for whatever reason. And so,
38 that's the first challenge is identifying how many people
39 in a particular community have suicided.

40
41 The second challenge is, as I mentioned when you're
42 calculating rates, you need an estimate of the size of the
43 community that suicides are drawn from. An estimate of the
44 size of the LGBTIQ community in Victoria, I don't think we
45 have an estimate that everyone would agree on. What I was
46 trying do was calculate some suicide rates among people
47 with diagnosed mental illness, and there are at least three

1 different lots of data on our estimates of what proportion
2 of the Victorian population has a lifetime diagnosed mental
3 illness or diagnosed mental illness in a 12-month period or
4 so on, and it's not clear what you even use.

5
6 So, there are other people who are epidemiologists and
7 experts who know far more about this than me, that's the
8 challenge that the court faces.

9
10 MS NICHOLS: Thank you very much Mr Dwyer, and thank you to
11 the Coroner's court for compiling this data for us. Chair,
12 do the Commissioners have any questions for Mr Dwyer?

13
14 COMMISSIONER FELS: Thank you, that was very informative.
15 A couple of questions that might be on the boundaries of
16 what you want to talk about. To what extent is the issue
17 of data a possible underestimate? It's probably not an
18 overstatement of it, but there are some that you don't
19 catch or don't come forward-looking like suicide et cetera.
20 That's one question. Is there an understatement in these
21 numbers of the number of suicides in the community?

22 A. We don't believe there is. So, all suspected external
23 caused deaths are among the deaths that are required to be
24 reported to the Coroner's court, and we run our
25 surveillance process across all deaths that are reported,
26 and we continually update our data as we learn more about
27 the deaths.

28
29 Where there's a grey area is in deaths for which the
30 intent of the deceased is unable to be determined, and
31 that's where different people may make different calls or
32 be happy to say, well I think that's a suicide but we think
33 it's not or so on, and the main area there is in overdose.

34
35 So, every year in Victoria, among the overdose deaths
36 that occur, 60 per cent are clearly unintentional,
37 20 per cent are clearly intentional, and we have another
38 20 per cent, so that adds up to maybe 130-odd deaths a year
39 where we just don't know on the basis of the evidence one
40 way or another.

41
42 And so, in the Victorian Suicide Register we do hold
43 data as well on deaths where the intent of the deceased is
44 said to be undetermined and, from memory, it's around a bit
45 over 100 deaths a year, but I could provide that data if
46 you wanted. So, we report on the data that we are
47 confident saying this is a probable suicide, including data

1 where the Coroner has found that the death was a suicide,
2 but for the other data we keep track of it but we don't
3 report on it. This material includes only the ones that
4 are probable suicides based on the evidence that we have
5 before us.

6
7 Q. My second question was, and you've mentioned this, the
8 Australian Bureau of Statistics published some numbers. Do
9 you have any comments on the relationship of their data to
10 your data?

11 A. I know that they use different methods, and for
12 example, for us a year means a year, deaths reported
13 between 1 January and 31 December in a year. But my
14 understanding is that their definition of a year is
15 slightly different: it's about when the case is initiated
16 in their system or something like that.

17
18 And also, the Australian Bureau of Statistics, they
19 draw their data or their information to identify suicides,
20 I believe, from the National Coronial Information System.
21 The National Coronia Information System is an online based
22 system that includes a range of information on deaths
23 reported to an investigator by Coroners, for example, the
24 initial police report of death, forensic toxicology,
25 forensic pathology and so on.

26
27 But what they don't have access to is all of the other
28 material that was generated in the course of the Coroners
29 investigation: so the statements of family and friends, the
30 statements of medical practitioners, medical material and
31 so on, and also all the other material that's generated
32 during the course of the correspondence and communication
33 between families and the court. And so, that I think would
34 account for some of the difference as well. I think we
35 have a better understanding on a case-by-case basis of the
36 circumstances of deaths.

37
38 It's not a criticism the Australian Bureau of
39 Statistics: they do their thing and we do ours, if you
40 like. We've attempted to assist them in the past as well,
41 but I think they have methods to follow

42
43 COMMISSIONER COCK RAM: Q. Thank you, I just wanted to
44 come back to the issues around the LGA and the capacity to
45 get down into a more regional level. And noting that you
46 have said you are assisting government with the place-based
47 trials, which in my thinking assuming you are looking at a

1 LGA level with the place-based trials?

2 A. Yes we are.

3

4 Q. Also that in your longer report it indicates the huge
5 variation which you described in the graph. So, how far
6 can we think about or aggregate around particular
7 communities, for instance, outer Metropolitan Melbourne
8 versus inner Metropolitan Melbourne; larger regional
9 centres and the associated LGA's around them? Is it
10 possible for us to get to a meaningful set of data,
11 understanding that it has to be meaningful, for us to draw
12 any conclusions?

13 A. It's possible to generate the data, that's not a
14 problem, but as to drawing conclusions, I mean, that's a
15 matter for you - not being trite or anything. Basically,
16 if you tell us what you want, then I think that we can
17 aggregate the data, we have it down to suburb level; we
18 actually have it down to street address level and then
19 built all the way up to LGA level. So, yeah, we can
20 combine the data geographically in any way that is
21 requested.

22

23 The thing is, once you start digging into the data at
24 a location level, it sort of opens up all of these
25 different avenues to go down to look at, so I think it's
26 important to have questions at the outset or else you can
27 get mired.

28

29 I mean, I did a version of this report that would have
30 had about 200 pages of data, it just wouldn't have been
31 helpful, I suspect. It's a matter of, with all the data
32 that we have, framing the questions to be answered, I
33 think, first

34

35 COMMISSIONER COCKRAM: Okay, thank you, that will be
36 helpful.

37

38 CHAIR: Q. Thank you very much for the overview. There
39 is one particular issue I wanted to also just clarify. Are
40 you able to disaggregate the data by age cohorts in terms
41 of their contact with the health services, both in the year
42 and six weeks before the suicide? Because I was
43 particularly interested in the 10-14 and 15-19 age group,
44 whether there's any differences in their help-seeking
45 contact?

46 A. Yes, we can definitely do that. But we also recently
47 published a paper - I mentioned earlier that we collaborate

1 with researchers who are interested in different aspects of
2 suicide prevention; we had a Paediatric Registrar do a
3 12-month placement in the court and she did a fantastic
4 piece of work looking at that exact question. Although, we
5 thought it was more meaningful to look at - I think we
6 looked at 10-16 versus 17-19, because at between 16 and 17
7 that's when you get post compulsory schooling and there's a
8 whole lot of other stressors involved there. So, we could
9 provide that paper to you and also disaggregate the data to
10 answer the questions that you're interested in, yes.

11
12 CHAIR: Thank you, that will be very helpful, so we'll
13 come back to you in relation to that. Thank you very much
14 for your evidence today.

15
16 MS NICHOLS: May Mr Dwyer be excused, please?

17
18 CHAIR: Yes, thank you.

19
20 MS NICHOLS: Chair, is it convenient to take the 15 minute
21 break now?

22
23 CHAIR: Yes, thank you.

24
25 SHORT ADJOURNMENT

26
27 MS NICHOLS: Commissioner, the next witness is Professor
28 Jane Pirkis. I call her now.

29
30 **<JANE ELIZABETH PIRKIS, affirmed and examined: [11.36am]**

31
32 MS NICHOLS: Q. Professor Pirkis, are you the Director
33 at the Centre For Mental Health at the Melbourne School of
34 Population and Global Health at the University of
35 Melbourne?

36 A. I am.

37
38 Q. Do your research interests focus on the epidemiology
39 of suicide, including the prevention of suicide at a
40 population level?

41 A. They do.

42
43 Q. We have a copy of your extensive CV, so I won't ask
44 you any questions about it, if that's alright.

45 A. Thank you.

46
47 Q. Have you, with the Royal Commission's assistance,

1 prepared a statement addressing the questions we have put
2 to you?

3 A. I have.
4

5 Q. I tender that statement. [WIT.001.0057.0001] Can I
6 ask you about the risk factors for suicide. Firstly, from
7 an epidemiological perspective in broad terms how are they
8 calculated?

9 A. So, the best way to think about it perhaps is that
10 epidemiologists would calculate the proportion of people
11 who have died by suicide who have a particular
12 characteristic or experience, and then compare that with
13 the proportion of the population who haven't died by
14 suicide who have similar characteristics and experiences.
15

16 Q. Broadly speaking, how are those characteristics
17 associated with people who have died by suicide? What sort
18 of investigations are done to establish that?

19 A. So, there are various different ways that
20 epidemiologists and others would look at risk factors.
21 Sometimes they do what they call psychological autopsy
22 studies, so they would talk to the family members and
23 friends of someone who's died by suicide and do comparable
24 investigations with family members and friends of people
25 who haven't died by suicide.
26

27 Sometimes they're done through what's called record
28 linkage studies, so data on suicides, like for example from
29 the Victorian Suicide Register, might be linked to other
30 data sources like mental health service use data, that sort
31 of thing.
32

33 Q. In relation to the first type of investigation,
34 questioning of family and friends of people who have not
35 died by suicide, is that in order to establish a control
36 group?

37 A. Yes, that's right. Obviously, they could ask the
38 living people themselves about their characteristics and
39 experiences, but there's a question about whether the kind
40 of information they'd get would be equivalent. So, because
41 the psychological autopsy studies are asking the family
42 members and friends of the people who have died take that
43 approach, they do the same with what they call the control
44 group.
45

46 Q. Are the risk factors for suicide traditionally grouped
47 into six subgroups?

1 A. Yes. So, people would often think about them as
2 socio-demographic. So, for example, men not being married
3 or not being partnered can be a risk factor for suicide.
4 There are clinical risk factors, like having a mental
5 illness or having made a suicide attempt.

6
7 Personality based risk factors like, for example,
8 impulsivity and aggression have sometimes been associated
9 with suicide. Neurobiological factors, genetic or familial
10 factors. Not quite sure how many I've got there.

11
12 Q. You have personality-based, I think you've discussed
13 that already. Situational environmental?

14 A. Sorry that's the last one, so situational or
15 environmental risk factors which is an important one.
16 Situational factors might be stressful life events.
17 Environmental factors might be things like access to means.

18
19 Q. Do you also distinguish between proximal and distal
20 risk factors?

21 A. That's right. So, people talk about proximal risk
22 factors as being risk factors that occur close to the
23 event. So, often they are stressors, recent stressful life
24 events, and more distal risk factors that perhaps have been
25 part of the person's life for a long time.

26
27 Q. How do proximal and distal risk factors interrelate in
28 the case of any particular suicide?

29 A. So, often, but not always, as others have said,
30 suicide is extremely complex and plays out differently for
31 different people, but often the proximal risk factors would
32 be the triggers or tipping point that might lead someone to
33 make that decision at that particular point in time.
34 Whereas the more distal risk factors are things that, I
35 guess, perhaps people might say lay the potential for
36 suicide.

37
38 Q. We'll come to interventions shortly, although not yet,
39 but just this question: do suicide intervention strategies
40 seek to intervene in relation to both proximal and distal
41 risk factors?

42 A. Yes, absolutely. People talk about universal and
43 selective and indicated interventions. The universal target
44 the whole population without particularly trying to
45 identify individuals in that population who might be at
46 risk. Selective interventions target people who are
47 showing some signs of the risk factors but not necessarily

1 suicidal thoughts or behaviours yet, and the indicated
2 interventions target people who are actively suicidal. So,
3 they consider suicide and its risk factors across the full
4 trajectory.

5
6 Q. We'll return to that subject very shortly, but can I
7 ask you about the relationship between mental ill-health
8 and suicide. What does the research that you and one of
9 your PhD students has recently completed show?

10 A. So, the PhD student is Angela Clapperton and she's a
11 PhD student who co-supervised, and she did some work
12 amongst other things using the Victorian Suicide Register.
13

14 What she showed was that mental illness is absolutely
15 a risk factor for suicide and so are stressful life events.
16 And stressful life events are things such as being in
17 trouble with the police perhaps or relationship
18 difficulties, are risk factors both for people with mental
19 illness and without mental illness, risk factors for
20 suicide.

21
22 Q. What did the research find about alcohol and other
23 drugs as a risk factors?

24 A. So, alcohol and other drugs absolutely also play out
25 as a risk factors.

26
27 Q. Was that true both males and females across all age
28 groups?

29 A. That's right.
30

31 Q. Can you explain the difference between risk factors
32 and probabilities?

33 A. Yes. So, well in fact, I would say that risk factors
34 are about probabilities really.
35

36 Q. I mean certainties, actually, I misstated the
37 question.

38 A. That's fine. The thing that sometimes people get a
39 bit confused about is they do think about risk factors as
40 certainties, but obviously they're not certainties. So,
41 having a mental illness acts as a risk factor for suicide,
42 but obviously not all people who have a mental illness die
43 by suicide, and conversely not all people who die by
44 suicide have a mental suicide. So, they're not about
45 certainties they're about probabilities, they're about
46 heightening the risk.
47

1 Q. And so, therefore, are prevention strategies aimed at
2 lowering the risk?

3 A. Yes, absolutely, and across the population, as I said.
4

5 Q. Did Ms Clapperton's research find that people both
6 with and without diagnosed mental illness who die by
7 suicide have multiple different immediate stressors in
8 their life?

9 A. Yes, absolutely.
10

11 Q. So, is the combination or accumulation of stressors an
12 important consideration in understanding risk factors?

13 A. Definitely, and also in understanding the complexity
14 of suicide, I think.
15

16 Q. Can I ask you now about suicide prevention
17 initiatives. Does suicide prevention refer to both
18 prevention of deaths by suicide, but also the prevention of
19 suicidal behaviour which includes suicidal thoughts and
20 suicide attempts?

21 A. Yes, that's right.
22

23 Q. Can we return now to what we started discussing a
24 moment ago, and that's the three types of interventions.
25 Can you tell the Commissioners a little bit more about
26 universal interventions?

27 A. So, as I said, universal interventions target the
28 whole population without identifying those who might be at
29 risk, and the reason they do that is because it's not
30 necessarily always evident who is at risk.
31

32 For example, they might include things like suicide
33 prevention awareness campaigns, or interventions designed
34 to restrict access to means, so it's not necessary for
35 those delivering the interventions to know who is at risk
36 in the population.
37

38 Q. Can I stop you there. With universal interventions,
39 do they also concern population level means to improve
40 wellbeing?

41 A. Absolutely, that's right.
42

43 Q. And, selective interventions?

44 A. So, selective interventions target people who aren't
45 necessarily exhibiting suicidal thoughts or behaviours but
46 have the risk factors that might lead them to in the
47 future: so those sorts of things include, for example,

1 providing good treatment for people with mental illness who
2 have mental illness because, as I've said, mental illness
3 is a risk factor for suicide, but are not necessarily
4 suicidal themselves at the time.

5
6 Q. And, indicated interventions?

7 A. Indicated interventions do target people who are
8 actively experiencing suicidal thoughts or engaging in
9 suicidal behaviour. So, they for example might include
10 crisis telephone lines, or treatment in mental health
11 services that are specifically designed to ameliorate
12 suicidal thoughts and behaviours.

13
14 Q. In your statement you say that it's your firm belief
15 that suicide is preventable: why do you hold that belief?

16 A. I hold that belief for two reasons: I hold it because,
17 having worked in the suicide prevention field for a long
18 time, both in a research capacity and just in a capacity of
19 talking a lot to people who have been through some sort of
20 suicidal crisis, people who have come through a suicide
21 attempt or a suicidal crisis are often able to say that
22 they're glad that they are still alive and also able to
23 talk about some of the things that were helpful or not so
24 helpful along the way. So, I feel that that's good
25 evidence, that suicide is preventable.

26
27 The other thing is that the vast majority of suicide
28 risk factors for suicide are modifiable, and so I believe
29 for that reason too.

30
31 Q. You also say that there's still a lot that we do not
32 know about what works and what doesn't work in suicide
33 prevention: why is that?

34 A. I think one of the reasons that there's still a lot
35 that we don't know is that suicide prevention research is
36 quite hard to do. It's often tricky because, if you're
37 trying to look at whether a particular intervention works,
38 suicidal individuals are often actively excluded from the
39 research. So, we find that the interventions might be
40 helpful but we don't know whether it's helpful for the very
41 people that we want it to be helpful for.

42
43 And also, although obviously every individual suicide
44 is a tragic event, and suicide is a major societal problem,
45 fortunately the absolute numbers of suicides are
46 relatively low, which makes it difficult to demonstrate
47 that an intervention has an impact in terms of reducing

1 suicides.

2

3 Q. So, why are suicidal individuals actively excluded
4 from some research?

5 A. So, quite reasonably, they're excluded because the
6 researchers and others involved in the research craft don't
7 want to do them any harm. So, it's a good thing that
8 people are protected in research, but there's a fine line:
9 it does mean that there are things that we don't know that
10 we would quite like to know.

11

12 Q. And that is because the therapeutic approach is to
13 give the person what is right for them, rather than
14 trialling the efficacy of a particular intervention?

15 A. Yes.

16

17 Q. One of the reasons you gave a moment ago for believing
18 that suicide prevention is possible is that, for people who
19 have had suicide attempts and survived talk about what was
20 helpful for them: is that something different from engaging
21 those people in research?

22 A. Yes, it's a bit of a nuance, but I think people who
23 are actively struggling with suicidal thoughts are more
24 likely to be excluded from intervention research because
25 there's an implication that the intervention might not be
26 the right one for them, or that they might be prevented
27 getting a different intervention that might be the better
28 one. So, they do tend to be excluded from that sort of
29 research, but they're more likely to be included in
30 research that's much more descriptive and which is a good
31 thing. Often, there are attempts to really hear the voices
32 of people with lived experience and hear from them what
33 they think works for them or has worked for them in the
34 past, and also what doesn't work for them.

35

36 Q. Can I ask you about global best practice on suicide
37 prevention. Can you tell the Commissioners what the World
38 Health Organisation's position is?

39 A. So, the World Health Organisation's, I think,
40 recognises that it is tricky and there's still a lot we
41 don't know in suicide prevention. So, they recommend using
42 a suite of different approaches taken from those universal
43 selected and indicated types of interventions. They
44 particularly recommend doing that in a strategic
45 coordinated national way. So, they make recommendations
46 about countries having national strategies for suicide
47 prevention.

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Q. What's understood to be particularly important about a national and strategic approach to suicide prevention?

A. So, I think one of the things that people, and the WHO, think is good about a national approach is that it shows the commitment of government to suicide prevention and indicates that it is a government priority, and also provides guidance as to where investment might be best placed.

The fact that it's coordinated, I guess the view is that that's a good thing because suicide prevention is everybody's business, and also, that it's not just in the bailiwick of health or mental health, there are a whole range of other sectors that have a role to play in suicide prevention.

Q. Can I ask you about what you call a systems-based approach: does that just mean coordination or is it something different?

A. So, I think when people talk about a systems-based approach they mean a similar thing to that national strategies approach that I was talking about, but they mean it at a more local level. So, there are a number of trials, as was said this morning, that are happening around Australia in the primary health networks trialling systems-based approaches which again involve picking a suite of interventions that are likely best bets and delivering them on the ground in a coordinated way. So the idea is that the whole is greater than the sum of the parts.

Q. Why is it important that a systems-based approach be embodied at a local level?

A. I think it's important at a local level because local areas are different. Translating the national approach to the local level gives local areas the opportunity to identify their own needs and tailor the approaches to their own needs.

Q. What would be an example, just in the abstract, of the types of needs that might differ from one community to the next?

A. So, for example, there was discussion this morning about the difference between urban and rural areas in terms of suicide and suicide prevention, so rural and regional areas have poorer access to mental health services, for

1 example. There are also particular professional groups
2 that might be more or less at risk of suicide, so some of
3 those sorts of things might influence how a systems-based
4 approach would play out on the ground.

5
6 Q. Can I ask you something about LifeSpan which is a
7 particular systems-based approach, we did hear a little
8 about this last Friday when Professor Helen Christensen
9 from Black Dog was here. From your perspective, can you
10 tell the Commission what that involves and how it's being
11 implemented?

12 A. So, LifeSpan is exactly that, it's a systems-based
13 approach. It involves a number of different interventions,
14 again some universal, some selective, some indicated, and
15 it's being delivered through primary health networks in the
16 various trials that are being run across Australia, so some
17 state-based trials and a national trial.

18
19 The Black Dog Institute worked quite tirelessly at the
20 beginning of the process to work out what the best bet
21 interventions might be to include in the LifeSpan approach,
22 and has also developed resources to help the PHNs with the
23 delivery of LifeSpan. So, Black Dog's been integral to the
24 whole process.

25
26 Q. Do you know whether the PHNs actually play a
27 coordination role on the ground, as it were?

28 A. Yes, I think they do. It probably differs a bit from
29 PHN to PHN, but the PHNs have a role in commissioning
30 services. So, the fact that they're commissioning a
31 variety of services gives them the opportunity to play that
32 coordination role and think about what the best mix of
33 services is.

34
35 Q. Can I ask you about the issue of restricting access to
36 means, which is one of the forms of intervention of which
37 you are quite familiar and have done some work; is that
38 correct?

39 A. Yes, that's right.

40
41 Q. What is the evidence in Australia and internationally
42 about how effective this is as an intervention?

43 A. So, it's one of the few interventions actually for
44 which there is really quite good evidence. So, there is
45 evidence that - particularly when the means of interest is
46 lethal and it's a common means of suicide, restricting
47 access to that means can have a big impact on not only

1 deaths by that particular method but also on the overall
2 suicide rate.

3
4 Q. Can you explain the difference between those two
5 things and why it is that restricting access to means can
6 make an impact on the overall suicide rate?

7 A. Yes. So, for the reasons that I was sort of alluding
8 to, that if you restrict access to a common means of
9 suicide, that accounts for a relatively large proportion of
10 all suicides and you can eliminate that or reduce it, then
11 you can reduce the overall suicide rate.

12
13 Q. What about substitutability or substitution of means,
14 meaning that if you restrict access to one means, a person
15 who is in suicidal crisis may go on nevertheless to find
16 another means?

17 A. Yes.

18
19 Q. The evidence from studies that have looked at
20 substitution tend to suggest that there is some
21 substitution, either to the same means in a different
22 context, or to other means, but there is an overall net
23 gain. So, although it doesn't solve the problem
24 absolutely, it certainly makes a dent in the suicide rate.

25 A. I guess the reason - I'm not sure whether I'm
26 pre-empting a question you're about to ask me?

27
28 Q. No, you were, but the question I was going to next, so
29 go ahead.

30 A. The reason people think that restricting access to
31 means is a useful strategy is that it literally does often
32 stop the person in their tracks and gives them the
33 opportunity to think about the choice that they're about to
34 make, which either means that hopefully they will then
35 themselves seek help or alternatively it gives someone else
36 the opportunity to intervene and hopefully guide them to a
37 better course of action.

38
39 Q. You mentioned before that effectiveness studies show
40 that this means of interventions is effective when the
41 means is lethal and where it's commonly used. Is there
42 also a consideration about the means being modifiable?

43 A. Yes, that's right. So, there are obviously some
44 methods of suicide that are less amenable to restricting
45 access to the means than others, but there are some where
46 you can absolutely make a difference if you can restrict
47 access.

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Q. And so, if there was to be a strategy of restricting access to means, they would need to consider those three features?

A. Yes, that's right, absolutely.

Q. Thank you. Can I ask you about your assessment of how Victoria's suicide framework compares with global best practice?

A. So, I think the framework is pretty consistent with global best practice. It certainly emphasises the suite of interventions, and it emphasises taking the universal selective and indicated approaches, recognising that the universal approaches, like building resilience, are going to have downstream benefits but they're quite upstream sort of approaches. But also recognising that you're absolutely always going to have to make sure that you look after someone who's actively suicidal as well, and in particular provide good aftercare for them if they've had contact with mental health services. So, from that perspective it is absolutely consistent with best practices.

Q. What about - I didn't know whether these are Victorian or Australian actually, but you can tell us, the guidelines for media reporting on suicide?

A. So, the guidelines for media reporting on suicide are national in Australia, they're known as "Mindframe", and they're very well regarded internationally.

The reason that people are concerned about the media reporting of suicide is that certain types of reporting have been shown to lead to so-called copy-cat acts. So, for example, reporting where the method of suicide is described in a lot of detail, or where the reporting is particularly prominent, just by way of example.

Conversely, there are some good things that the media can do as well, like providing Helpline information if there is a story about suicide. So, those sorts of pieces of advice are embodied in the Mindframe guidelines and, although there are other similar guidelines around the world, the folk from Everymind who rolled out the guidelines have done a particularly good job with involving journalists and other media professionals in developing the guidelines and in getting them embedded in a journalism school curriculum, and in having Codes of Practice of media organisations, so they're very well regarded.

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Q. The place-based trials that are currently occurring in Victoria, you're not involved in assessing those, are you?

A. No, not in any major capacity at all.

Q. But as far as you know, the assessment's still going on, so we don't know --

A. That's right, yes. So in fact it's true with all of the trials, that they're all being evaluated, but the evaluations are ongoing with all of them, so it's a kind of "watch this space" time at the moment.

Q. Can I ask you about the things that you have focused on in answer to our question, what you think the Commission should recommend about suicide prevention. You have focused on universal measures which I think we've already discussed and restricting access to means.

One of the other things you say in your statement is that:

"Clinical mental health services need to be able to offer consumers all possible mental health assistance, not just individuals who have shown signs of suicidal behaviour, and to achieve this we need to provide optimal conditions for staff working in the mental health system."

Can you say a little bit more about that?

A. Sure. So, the reason I say that is for the reason I was talking about earlier, that mental illness is obviously a risk factor for suicide, but although we know that it is a risk factor for suicide and there are other risk factors for suicide, trying to predict which individuals will make a suicide attempt is very difficult, in fact almost impossible. So, clinical prediction tools really are not very useful.

So, because it's so difficult for mental health services to predict who might be at the absolute most risk, I feel like there's an onus on mental health services to provide optimal mental health care to all: it's kind of the best of the selective interventions, really.

But, in order to do that, the workforce needs to be well equipped to do that. I think that the Victorian

1 mental health workforce is extremely well intentioned but
2 very stretched, so I think further support to the workforce
3 in terms of numbers, perhaps also in terms of thinking
4 about how the workforce might be structured, and thinking
5 about including a greater peer workforce might be
6 beneficial things to do.

7
8 Q. What do you say about the importance of providing
9 assistance to people who are discharged from a clinical
10 service after a suicide attempt?

11 A. So again, that is regarded as a really good indicated
12 intervention. People who have been discharged from a
13 mental health service after a suicide still are often at
14 quite a heightened level of risk, so good follow-up care is
15 necessary for them; good integrated follow-up care.

16
17 Q. Finally, you've mentioned the need to strengthen the
18 evidence base about what works and what doesn't. What are
19 the areas in which more research is and isn't needed, and
20 why is it needed if it is?

21 A. So personally I feel like, having worked in the
22 suicide prevention research area for a long time, I feel
23 like we've done a pretty good job of all of the background
24 epidemiological research that describes the risk factors; I
25 think we basically know what the risk factors are. But
26 what we've struggled with is doing good intervention
27 research and really working out what works, and equally as
28 importantly what doesn't work in suicide prevention. So,
29 for my money, I'd be putting it into good, solid
30 interventions.

31
32 I guess the other thing I'd say about that is that I
33 realise that, in practice on the ground, it's not like we
34 should be doing nothing in the meantime waiting for the
35 best evidence to come in; obviously, we have to do the best
36 we can, so I think given that, there's an onus on those who
37 are funding and delivering services to make sure that
38 particularly novel interventions are being evaluated along
39 the way.

40
41 Q. What makes you of the view that interventions will
42 contribute to the reduction in suicide?

43 A. Well, I guess it comes back to what I said earlier
44 about a lot of the risk factors being modifiable. I think
45 if we can develop the ideal suite of interventions that
46 does target people at different points in the trajectory,
47 recognising that, as I said before, the trajectory is

1 different for different people and suicide is very complex,
2 I think we just need to crack the nut of the best ways to
3 intervene to help people who are at that point.

4
5 Q. Thank you, Professor Pirkis. Is there anything else
6 that I haven't asked you about that you want to raise with
7 the Commissioners?

8 A. No, I think that's it, thank you.

9
10 MS NICHOLS: Chair, do the Commissioners have any
11 questions?

12
13 CHAIR: Yes, Professor Fels.

14
15 COMMISSIONER FELLS: Q. Thank you for your excellent
16 evidence, Professor Pirkis. You just mention in here
17 impulse suicide. Could you perhaps say a little bit more
18 about that?

19 A. Sure. So, when I was talking about the reason that
20 people think that restricting access to means works, and I
21 said that people are of the view that it stops the person
22 in their tracks and allows either them to choose a
23 different course of action or for someone else to
24 intervene, one of the things that some people say is, it's
25 particularly useful with impulsive suicides, and you can
26 see why that might be so.

27
28 Personally, I think that it's probably useful for more
29 suicides than just impulsive ones. I think that, if you
30 talk to people who have been through a suicidal crisis,
31 they will often tell you that they were very ambivalent
32 along the way. So, although you wouldn't describe their
33 suicide attempt as impulsive, there would definitely be
34 points at which restricting access to means might have been
35 helpful. So, I said it in that context in my statement.

36
37 Q. Just in general, much has been said about suicide, and
38 national strategies and all these kinds of things, but the
39 numbers appear to have been no longer than they have been
40 for a long time. Now, reading your witness statement gives
41 me some idea of what the problems might be, but have you
42 got anything to say about the fact that the number has just
43 not gone down?

44 A. Yeah. Well, I think it is to do with the fact that we
45 still haven't really quite cracked the nut. We've got
46 better and the evidence base is building, but there's still
47 a lot that we don't know, and I would say that there is

1 still more that we don't know than we do know.

2

3 CHAIR: Thank you, Professor McSherry.

4

5 COMMISSIONER McSHERRY: Q. Professor, thank you very
6 much for your evidence today. You mentioned in your
7 statement that there are global challenges and that at
8 least we have a national strategy and so on, but you've
9 also spoken about the need for international
10 collaborations. I'm just wondering, are there any
11 countries that you know of that are trialling interventions
12 that do seem to be quite positive?

13 A. Well, I guess there are pockets, but I think that
14 Australia's probably doing just about as well as other
15 countries: everyone is struggling with it. So, the sort of
16 contemporary solution is to try to deliver this suite of
17 interventions, and so there are other countries that are
18 doing that as well, but I don't think anyone else has - no
19 other countries have demonstrably massively reduced their
20 suicide rate and we're going, let's look at them, let's
21 look at what they've done.

22

23 COMMISSIONER McSHERRY: Thank you.

24

25 CHAIR: Dr Cockram.

26

27 COMMISSIONER COCKRAM: Q. I'm going to get to the
28 epidemiology of suicidal ideation and suicide, that's where
29 it's heading, this question. We acknowledge that the
30 system has been, it's stressed and we've heard that a lot
31 through our processes. Yet we've also heard from a lot of
32 community witnesses about presenting to emergency
33 departments with loved ones, or themselves, expressing
34 suicidal ideation clearly feeling at risk and in distress,
35 and the system has provided a relatively - or seemingly -
36 relatively brief intervention at that point.

37

38 Can you assist us with trying to understand where some
39 of the epidemiology might be around suicidal ideation and
40 suicide and is there something in there that explains that
41 circumstance to us?

42 A. I'm not sure, really. I don't know, epidemiology can
43 answer that question. I think it's a very tricky question.
44 The rates of suicidal thinking, suicidal ideation, are much
45 higher than the rates of suicide attempts, and equally the
46 rates of suicide attempts are much higher than the rates of
47 suicide. I think that comes back to it being difficult to

1 predict: who of those people who are thinking about suicide
2 are going to move onto that next step.

3
4 Q. Would it be fair to think that there is some process
5 going on within the clinical system that is trying to make
6 that assessment based on, have they got a factual base to
7 base that assessment, a kind of set of risk factors that
8 they are thinking, this person is expressing a thought but
9 isn't going to and this person --

10 A. Yeah.

11
12 Q. Is there a risk factor analysis between the ideation
13 and the attempt that is coming into play here?

14 A. I can't really answer that, I can't speak on behalf of
15 the clinicians who are --

16
17 Q. But from an epidemiology point of view there isn't?
18 There's no evidence to say people with this ideation --

19 A. Well, you could find risk factors for people who are
20 thinking about suicide that might lead them to be the
21 people who then make a suicide attempt, but they're still
22 not going to be sensitive or specific enough to be able to
23 help you go, well, we really need to be particularly
24 careful about that person; there'd just be too many false
25 positives and false negatives.

26
27 Q. Just one last point to try and continue to understand
28 this. It would seem from the epidemiology then that this
29 is a group where all should get the selective or indicated
30 intervention.

31 A. Absolutely, I think so.

32
33 Q. There shouldn't be a choice, everyone should get
34 something at that point?

35 A. I think that's right, yes.

36
37 CHAIR: Q. Sorry, can I just follow up on that point,
38 because I did notice in your evidence earlier you said that
39 clinical prediction tools are not very helpful. I guess
40 that leads me to think about, given the evidence we've
41 heard at this Royal Commission to date, what does that mean
42 for the current triage tools that are the primary tool that
43 seems to be being used to differentiate who gets a
44 follow-up service from a CAT Team, for example, who
45 presents at an Emergency Department might then be referred
46 on for admission into a unit, who gets what type of
47 clinical follow-up on discharge. Am I correct in saying

1 you are questioning the relevance of that?
2 A. Well, I think that there's a difference between tools
3 that might guide the particular care that a person gets
4 from predictions tools that are designed to predict who is
5 at the absolute most heightened risk. So, I think triage
6 tools definitely have a role to play, but I do think it
7 comes down to not trying to predict in an individual case
8 who is at the most heightened risk but providing good care
9 to everyone.

10

11 Q. Am I correct in thinking that means you have to be
12 cautious when someone is presenting and seeking help in a
13 distressed state with suicidal ideation, for example?

14 A. Yes, absolutely.

15

16 Q. Because it's hard to differentiate the outcome?

17 A. Absolutely.

18

19 MS NICHOLS: Two of my follow-up questions have been dealt
20 with by you, Chair. May the Professor be excused, please?

21

22 CHAIR: Yes, thank you very much, Professor, for your
23 comprehensive information and your evidence today.

24

25 <THE WITNESS WITHDREW

26

27 MS BATTEN: Chair, the next witness is the subject of a
28 restricted publication order. I understand that you will
29 read out the terms of the order.

30

31 CHAIR: Thank you.

32

33 Pursuant to the Inquiries Act 2014, the Royal
34 Commission has made an order that prohibits the publication
35 of any publication that might enable the identity of: (a)
36 the next witness who will be referred to as the pseudonym
37 Susan Trotter; (b) her son who will be referred to as the
38 pseudonym Rowan Trotter; or (c) any family members of Susan
39 or Rowan.

40

41 A copy of this order has been placed next to the door
42 of the hearing room. The hearing of Susan Trotter's
43 evidence will be limited to the people attending today's
44 hearing. For those watching on the live stream, this
45 portion of the hearing today will not be broadcast. I will
46 now ask that the live stream be cut.

47

1 (Live stream cut.)

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3 MS BATTEN: Thank you. I now call Susan Trotter.

4

5 <SUSAN TROTTER, sworn:

[12.17pm]

6

7 MS BATTEN: Q. Thank you, Susan.

8 A. Thank you.

9

10 Q. Have you, with the assistance of the Royal Commission
11 team, prepared a witness statement for the Commissioners?

12 A. I have.

13

14 Q. I tender that statement. [WIT.0001.0043.0001] Susan,
15 can you start by explaining why you're here to give
16 evidence today, please?

17 A. I'm here to give evidence today on behalf of my son
18 who took his life by suicide [REDACTED] on Christmas Day, and
19 also other parents who I actually look after in a support
20 group so that they don't have to go through the pain and
21 the suffering of what becomes the aftermath of suicide.

22

23 Q. We would like to hear your story, and can we start,
24 please, when your son was 5 years old; can you tell us what
25 was happening in his life then and what help you sought at
26 that point?

27 A. When my son was 5 years old, I noticed that he was
28 very disruptive in his class and so did the teachers, so
29 they asked me, requested me to go to a public hospital
30 system and have him assessed. He was assessed with
31 attention deficit syndrome, and back then there was not
32 really any medication or systems that could support you
33 except various appointments and ways of trying to keep him
34 calm and helping him through his schooling.

35

36 Q. And then, you were a single mum when your son was
37 about 9?

38 A. Yes.

39

40 Q. And so, you looked after your son and your other
41 daughter as best as you could?

42 A. That's right.

43

44 Q. When your son was about 10 years old, you noticed that
45 he was not able to read and write very well?

46 A. Yes.

47

1 Q. Can you tell us about that point in his life then,
2 please?

3 A. Yes. I then asked the school if I could find out if
4 Rowan could be assessed for any problems, and they did an
5 educational assessment on him and they discovered that he
6 had borderline intellectual disabilities. So, for that
7 reason, that's why he wasn't picking up to be able to read
8 and write, because his memory, short-term memory, wasn't
9 available.

10

11 Q. And then you've said in your statement that he was
12 bullied a lot as a result of that from school?

13 A. Yes, he was very badly bullied, even by the teachers
14 as well at the school. He was just too much to handle for
15 them to look after, so I suggested that he should go to a
16 special supported school. They suggested, no, that he was
17 not bad enough to be put into that school and they would
18 support him, but the supports were not there. But he was
19 very smart, he knew how to do his comical little acts to
20 keep everybody away from him to make funny jokes so that
21 they would understand all about him and accept him.

22

23 Q. Then you've said, when your son was in Year 9, he just
24 could not cope with school any more?

25 A. No, he couldn't.

26

27 Q. What was going on at that point? You had him
28 assessed?

29 A. I took him to the GP and the GP suggested - he wrote a
30 letter to take to Centrelink and the Centrelink doctors
31 assessed him, and said that he would not be able to work
32 because of his short-term memory loss and attention deficit
33 syndrome, and also his borderline intellectual disability,
34 so they put him on a disability pension.

35

36 Q. And then you've said your son's mental health seemed
37 to deteriorate when he was around 17?

38 A. Yes, he got very angry, he was frustrated with
39 himself, he felt that he wasn't getting the supports that
40 he needed, and he then took his first attempt of suicide.

41

42 Q. After he'd taken his first attempt at suicide, you
43 went to the hospital?

44 A. That's right, in a public hospital system.

45

46 Q. Can you tell us about your experience at the hospital
47 at that point, please?

1 A. It was at the Emergency Department, and everybody was
2 trying to make him feel okay, because he had to have his
3 stomach pumped and I had to wait till he woke up from his
4 overdose, and they suggested to me that he needed to see a
5 psychiatrist and have medication. So, they sent me home
6 with a letter and it took two to three months before we
7 were able to see a counsellor or a psychiatrist.
8
9 Q. Why did it take two to three months?
10 A. The waiting list.
11
12 Q. After two to three months he got to see a counsellor?
13 A. Yes, he did.
14
15 Q. Did he also have a case manager at that point?
16 A. He did, he had a case manager. He also was put on
17 medication, antidepressants.
18
19 Q. For his mental health journey, did he have the same
20 case manager all the way along?
21 A. No. No, there was all different case managers because
22 of the workload and the support that was needed.
23
24 Q. You said your son was referred to a psychiatrist: did
25 he go and see a psychiatrist?
26 A. Yes, he did.
27
28 Q. What did the psychiatrist say?
29 A. That's when they said that he had personality disorder
30 and he also needed to be on antidepressants as well.
31
32 Q. In between the ages of 19 and 21, you've said that
33 your son was pretty angry --
34 A. Yes.
35
36 Q. -- with himself and he was going through a difficult
37 time.
38 A. That's true.
39
40 Q. What was happening at that point in time?
41 A. He was very frustrated with himself, he felt that he
42 wasn't normal and he felt that nobody was helping him or
43 supporting him to what he needed. He hated taking the
44 medication, I know that for a fact, so he had several
45 suicide attempts, and it was the same situation: 24-hours,
46 48 hours at home he'd go after he woke up out of comas.
47

1 Q. 24-hours or 48 hours at the hospital and then he was
2 sent home?
3 A. Yeah, and then he was sent home in my care.
4
5 Q. And then, did the CAT Team come and see him?
6 A. Occasionally, yes: sometimes they would turn up and
7 sometimes they didn't.
8
9 Q. You've said each time the hospital released your son
10 they told him to keep up his medication and treatment?
11 A. Yes, and that was done by a GP, the medication.
12
13 Q. When your son was around 21, he was referred to live
14 in a supported living arrangement?
15 A. Yes.
16
17 Q. Could you tell us about the supported living
18 arrangement?
19 A. It was excellent. They were teaching him living
20 skills, how to be competent, to look after himself. I was
21 involved, which was excellent. They would have parents
22 there and we'd learn, we'd have cooking nights, et cetera,
23 and he was being taught how to look after his money,
24 because with that problem he couldn't look after his money
25 at all. And also, they were there 24-hours and whenever he
26 needed to talk to somebody, or he felt that suicidal
27 attempt come up, he would have somebody there to talk to.
28
29 Q. And who's "they" that were there to talk to, were they
30 the counsellors?
31 A. They were the counsellors and also the support workers
32 who live there, live in basis.
33
34 Q. Your son was still fighting his demons during this
35 period, you said?
36 A. Yeah, all the time, he was always fighting his demons.
37
38 Q. Did he have any suicide attempts while he was in the
39 supported accommodation?
40 A. No, he didn't. He used to feel that he wanted to, or
41 he'd talk about it but they were there for him and I was
42 there for him as well.
43
44 Q. And they also ensured that he took his medication?
45 A. Yes, and that was one thing that was really major.
46
47 Q. And so, he was in there for five years, and then he

1 got married and he moved out of that supported
2 accommodation?
3 A. That's true, yes.
4
5 Q. And so, by this time he's about 26?
6 A. Yes.
7
8 Q. You've said for two or three years your son was in a
9 constant cycle of issues, overdoses and recoveries?
10 A. Yes.
11
12 Q. Can you tell us about this period in your son's life?
13 A. It was very distressful for me and distressful for
14 him. We were in and out of various hospitals, weeks on
15 end, waiting for him to come out of comas, with no
16 supports. He actually felt sometimes like he was a
17 criminal, that he was doing something wrong. We'd had
18 various family meetings. In one of the meetings I was
19 actually told that my son was an attention seeker and that
20 he would never really take his own life.
21
22 Q. You also said that there was a constant rollercoaster
23 of hospital after hospital?
24 A. Yes, lots of hospitals.
25
26 Q. And then, usually when you went to a hospital, how
27 long was your son in the hospital for?
28 A. 24-hours to 48 hours.
29
30 Q. And then, did he have one admission during this time
31 as well?
32 A. Sorry?
33
34 Q. Did he have one hospital admission at one point for
35 two weeks?
36 A. Yes, he did, for a week to two weeks.
37
38 Q. But there was just the one admission generally he was
39 in for 24 or 48 hours?
40 A. Yeah.
41
42 Q. And released back to you?
43 A. M'hmm.
44
45 Q. You've said that you felt like your son was being let
46 down because the hospitals didn't follow through after he
47 was released?

1 A. Yes, very badly let down.

2

3 Q. When he was released to you, what contact did he have
4 from the hospitals?

5 A. Not very much at all. Nothing at all. He might get a
6 phone call maybe once or twice, but none of that continued,
7 it was just continuously going to the GP or going to the
8 counsellor or his CAT Team or case manager.

9

10 Q. Moving to when your son was 28. When he was about 28,
11 your son became a dad?

12 A. Yeah, and he was the most happiest to be a dad. He
13 loved his son so much, and he said to me, "I promise you,
14 mum, now that I have him I will never try to take my life
15 again because I have something to live for."

16

17 Q. And your son tried every day?

18 A. He did. He tried every day, and at times he would
19 come to my work where I worked, which was very embarrassing
20 for me sometimes, but he'd come; he didn't worry about time
21 or anything, he'd just be there when he needed to talk, and
22 he would talk to me about what he was feeling and I would
23 sit there and talk to him and discuss things, like, "You
24 know that you need to be here for your son. You need to
25 stay around and I'm here to help you, and I'll do anything
26 I can in any way."

27

28 Q. Can we talk about Christmas [REDACTED]?

29 A. Yeah.

30

31 Q. You said two days before Christmas [REDACTED] your son
32 came to your work?

33 A. Yes.

34

35 Q. And he had some court papers with him?

36 A. That's right.

37

38 Q. [REDACTED]
39 [REDACTED]
40 [REDACTED]
41 [REDACTED]
42 [REDACTED]
43 [REDACTED]
44 [REDACTED]
45 [REDACTED]
46 [REDACTED]
47 [REDACTED]

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[REDACTED]

Q. You since learned what happened during that day. Can you talk to us about what you know happened?

A. Yeah, he then decided that he would take all his prescriptions to each different chemist, he'd also gone to the GP and got more prescriptions, and he took a major overdose.

Q. You said that his girlfriend found him and rushed him to hospital?

A. Yes. He didn't think anybody was coming back to the unit, and she had forgotten something so she'd gone back in and she found him in the shower and he was completely nearly gone. She rang the ambulance and in the meantime I was ringing, because we were all going away together, and I kept ringing and then finally she answered the phone and he was in the ambulance and he was nearly gone, they had the paddles on him, and in a way I wished he'd gone that way than the way he actually did.

So, he was then taken into the public hospital, into the Emergency Department. The run-around started again. I was assured by his girlfriend that he was okay and I should stay where I am with my other family. Because, when you've got somebody with those sort of issues as well, your family really isn't really supportive sometimes with you, so I was torn between my family and also running to him, so I didn't run to him like I usually would because I trusted the hospital and [REDACTED].

Q. Did you speak to the hospital?

A. I did, at various times. Various times I was put on hold by different registrars and different residents, and I was told that, you know, just to wait and see how he is when he wakes up. And, when he finally woke up, the first thing that he said to me was that, "I don't want to be here. [REDACTED], I don't want to be here. Do

1 you understand?" And I just said to him, "Now, come on
2 mate, you can't talk like that. You're okay, you'll be
3 okay, we'll be okay." Then I spoke to the residents and I
4 said that to him, and he said to me, "Don't worry, he's
5 okay." Rowan told us he's okay."
6

7 Q. Then you spoke to the hospital again on Christmas Eve?
8 A. Yeah, a couple of days, yes, and Christmas Eve,
9 because Christmas Carols by Candlelight were playing in the
10 background as well, and I begged them to hold on to him
11 until Boxing Day, because that's when I could come and pick
12 him up. I begged them, "Please, hang on to him because
13 he's not in a good way." They told me they would.
14

15 And then Christmas morning I got a call from my son to
16 tell me that he had been released - no call from the
17 hospital, [REDACTED]

18 [REDACTED]
19 [REDACTED]
20 [REDACTED]
21 [REDACTED]
22 [REDACTED]
23 [REDACTED]
24 [REDACTED]

25 [REDACTED], and then he and his girlfriend
26 went home, were going home, and as they were on the tram -
27 because Rowan was a very strong-willed guy -
28 - as they were on the tram he said to his girlfriend, "I'm
29 getting off and you stay here" and he jumped off the tram.
30 And then he went down to the railway lines and that's where
31 he sat for a couple of hours.
32

33 I actually rang him at 2 in the afternoon because I
34 was worried about him, asking if everything's okay, and he
35 said to me, "Don't worry mum, I'm fine, I'm going to the
36 pictures and I'm going to go and see [REDACTED]." And I said,
37 "Okay mate", and he said, "Don't forget, mum: love you",
38 and I then I hung up. About two hours later I started to
39 worry, I had a horrible feeling in my stomach because I
40 hadn't heard from him, and the phone was continuously
41 engaged, and engaged, and engaged.
42

43 And I didn't know what was going on, and then I got a
44 call from his girlfriend telling me that they didn't know
45 where he was, and they'd rung the police and they thought
46 he might have been up at the Hurstbridge railway lines
47 because that's where his mate actually lived. But Rowan

1 had gone somewhere where it was very familiar to him that
2 was very emotional to do what he needed to do, [REDACTED]
3 [REDACTED].
4

5 And then I got the call at 6.20 to tell me what he had
6 done and that he had died. That day absolutely destroyed
7 me and for the rest of my life now all I think of is, why,
8 if, but, if only. And that's why I run these support
9 groups, to help other parents that go through the same pain
10 and suffering that I feel every day of my life.
11

12 Q. Can you tell us a little bit more about the support
13 groups, what are those support groups?

14 A. After I lost him, I was an absolutely mess. I had
15 been to the Coroners because I had to view him, which was
16 very hard, and they gave me some brochures. I put the
17 brochures away because I didn't think of anything, I didn't
18 want to be here to tell you the truth, I felt so much guilt
19 and hurt inside.
20

21 So I rang Compassionate Friends three months later,
22 and I'd been to counsellors and everything, but I just
23 didn't feel that's what I needed, and the GP wanted to give
24 me antidepressants and I didn't want them because I knew
25 what they had done to him, and I knew I'd just buried my
26 son, why would I need antidepressants?
27

28 So I rang up and the first thing - it was a 24-hour
29 call line, and they said, "You could come to our first
30 meeting." The first time I was going to the meeting was in
31 Waverley, which was a long, long way from where I lived, it
32 was a suicide only meeting, after you lose your child.
33

34 I sat outside for about an hour to two hours because I
35 was so nervous of going in there, but the moment I walked
36 in there, and I got the cuddles and the relaxed atmosphere,
37 and once I started talking and listening to everybody else
38 who was talking and explaining how they felt, I knew I
39 wasn't going crazy any more; I knew that this was grief and
40 this was what I was dealing with.
41

42 I continued going to the groups. Once a month I'd
43 make my way to get there and I got to know a lot of people.
44 Then there was a chance of doing the course, a lifeline
45 course, and I did that course for eight weeks every
46 Saturday so I could become a support person.
47

1 So then, I started to be a support person over at
2 Canterbury, that's where the main office is that helps all
3 us lovely people who are going through all this horrible
4 stuff, and they said to me - I found it was so hard to
5 drive there all the time so I decided we needed something
6 in the Western Suburbs, because parents who are going
7 through this don't want to travel through peak hour traffic
8 and be under that stress all the time; it's hard enough
9 trying to deal with what you're dealing with.

10
11 So, I approached the Salvation Army and I found a
12 centre that we could go to for free. So, I now counsel
13 parents who come to me after their children die of suicide.
14 And, when I do counsel these people, I don't just take them
15 into a group straight away: I take them for coffee, I talk
16 to them, I tell them what the groups are all about, I tell
17 them my story and they understand they're talking to
18 somebody who has lived this experience, that knows what
19 it's like to go through all of this.

20
21 I've been doing this for five years and I still keep
22 seeing parents being let down by the mental health system,
23 which breaks my heart.

24
25 Q. Are there some recommendations that you wanted to say
26 to the Commission?

27 A. I do, yes. I would like to close with a plea to the
28 members of the Royal Commission: please, do all you can to
29 prevent any parent having to deal with the enormous
30 aftermath of losing a child to suicide, having to deal with
31 the hurt, loss, guilt for the rest of our lives.

32
33 If you can somehow find a magical band-aid to fix this
34 broken system, like the words I would say to my son when as
35 a child I would fix his hurt knee with a band-aid.

36
37 Thank you.

38
39 MS BATTEN: Thank you very much, Susan. Chair, are there
40 any further questions for Susan?

41
42 CHAIR: No, I don't think so. Thank you very much, Susan,
43 for coming and being so prepared to share your journey with
44 us and to tell us about the ongoing support that you're
45 providing to other families. So, thank you very much
46 indeed.

1 MS BATTEN: May Susan please be excused?

2

3 CHAIR: Yes.

4

5 <THE WITNESS WITHDREW

6

7 MS BATTEN: The next witness will come at 2 o'clock, so may
8 we adjourn for lunch?

9

10 CHAIR: Yes, thank you.

11

12 **LUNCHEON ADJOURNMENT**

13

14 **UPON RESUMING AFTER LUNCH**

15

16 MS BATTEN: The next witness is Mr Allen Woodward. I call
17 Mr Woodward.

18

19 <ALAN ROGER WOODWARD, affirmed and examined: [2.02pm]

20

21 MS BATTEN: Q. Thank you, Mr Woodward. Have you, with
22 the assistance of the Royal Commission's legal team,
23 prepared a witness statement for the Commission?

24 A. I have, yes.

25

26 Q. I tender that statement. [WIT.0001.0055.0001]
27 Mr Woodward, could you please start by outlining for us
28 your background and experience in the field of suicide
29 prevention?

30 A. I've worked in the field of suicide prevention and
31 related health and human services for more than 20 years
32 now. In the last 15 years in particular, I have focused on
33 services and programs relating to suicide prevention. I
34 worked for 14 years for Lifeline Australia in various
35 executive roles, including the establishment of the
36 Lifeline Research Foundation.

37

38 I also have been a board director with Suicide
39 Prevention Australia for nine years during that period. I
40 currently work independently providing advice to a range of
41 organisations, including Suicide Prevention Australia,
42 Mental Health Victoria and others, and from August
43 this year I shall take up a part-time appointment as a
44 National Mental Health Commissioner.

45

46 Q. Your evidence today is given on your own behalf, it's
47 not given on behalf of any organisation; is that right?

1 A. That's correct, I'm not representing any single
2 organisation today.

3
4 Q. Could you tell us what are some of your key learnings
5 from working in the field of suicide prevention for
6 20 years?

7 A. Yes. It's a field where there are some complications
8 and nuances and many twists and turns in understanding what
9 is really one of the most perplexing of human behaviours:
10 the desire and intent to end one's life.

11
12 I've learnt many things around the complexity of
13 suicidal behaviour and the range of strategies for suicide
14 prevention, but if there's one thing that's stood out to me
15 over the time, it's that suicide is fundamentally a story
16 of human tragedy and suffering.

17
18 That's perhaps the starting and the finishing point in
19 any understanding around suicide and its prevention: it is
20 about people who reach profound despair and pain and can
21 see no other way out of that pain other than to end their
22 life. It's the stories of those who experience trauma and
23 loss and grief through the suicidal actions of others and
24 sometimes their deaths.

25
26 Suicide is one of those destructive and tragic forces
27 within our social fabric that, as a community, we would
28 like to endeavour to prevent in any way possible.

29
30 Q. Thank you. We'll return to some of those themes as we
31 go through your evidence. Just to clarify the parameters,
32 can you explain to us what you mean when you say suicide
33 prevention?

34 A. I think there are a number of layers to suicide
35 prevention. First and foremost, it is about the prevention
36 of preventable death. And all of us working in the field
37 of suicide prevention are motivated, profoundly, by the
38 desire to prevent needless death and the belief that
39 suicide deaths are preventable.

40
41 Q. Why do you hold the belief that suicide deaths are
42 preventable?

43 A. Well, because suicide is a human experience, it drives
44 a behavioural response, and therefore there are things that
45 can be done to mitigate the factors that might lead to a
46 person's suicidality becoming so intense as their intention
47 to end their life.

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But also from, I guess, a more philosophical belief in the value of life and the promotion of life as we would against other forms of preventable death: we want people to live and we want them to have participating lives.

Q. So, preventing deaths was the first element of suicide prevention; are there other layers that you want to mention?

A. Yes. Importantly, suicide is also around non-fatal behaviour, and the experience of profound despair and pain. Therefore, it may be manifested through attempts to end one's life or other forms of suicide or crisis and, while those may not result in death, they are still highly traumatic, damaging processes for the individual concerned and those around them.

So when we talk about suicide prevention, in my view, we're also keen to prevent traumatic and destructive periods of crisis.

Q. Does that encompass the impact on other people?

A. It does indeed, and this is another aspect of suicide prevention. No person who is suicidal and in crisis is without an impact on others, and a death by suicide has a far-reaching impact on others. So, suicide prevention is also about recognising the importance of preventing suicide in the wider community so that families, social networks, workplaces, sporting groups also, are not affected by suicide.

Q. You have stated:

"Research has shown that the impact of suicide deaths and behaviour on others is so profound that it would raise a public health concern."

Can you please elaborate on what you mean there?

A. Yes, there is emerging evidence to suggest that the impact of one person's death by suicide can have a profound affect on the wellbeing of others. Some of that can be related to the trauma and related grief and loss, but also, there is something powerful about suicide that it can have a spin-off effect on others and those who are impacted by one person's suicide can sometimes find themselves feeling suicidal.

1
2 So, in that sense, we are keenly aware of the
3 potential contagion factors of suicide reaching beyond
4 those who die by suicide and having a far-reaching effect.
5 We also have more knowledge nowadays as to the
6 quantification of that impact. We know, for example, from
7 meta-analysis that around 5 per cent of the population may
8 be impacted by others' suicide deaths in any 12 months.

9
10 So, in Australia, while there are 3,000 plus deaths by
11 suicide each year, there are many thousands more who are
12 impacted by those deaths. We also know that it impacts
13 across relationships, certainly family relationships, but
14 not only family relationships; relationships of friendship,
15 colleague relationships, social networks.

16
17 Q. You've referred to "5 per cent of the population", is
18 that any population? Which population are you referring to
19 there?

20 A. The research is undertaken by Karl Andreas and other
21 researchers as a meta-analysis focuses primarily on western
22 studies but across many nations. So, we might see that
23 study suggests 5 per cent of the population in 12 months
24 and quite plausibly in Australian population.

25
26 Q. You've referred to the best way to understand suicide
27 is a person's desire not to live as an expression of
28 profound human suffering. Can you expand on why you think
29 that's the best way to view suicide?

30 A. Well, it was insight that was gained from the 50s and
31 60s through some of those who were working in the field.
32 Most notably Ed Shniedman, Bob Lictman and Norm Favaro
33 through psychiatrists operating in Los Angeles who did
34 intensive and very important work in the area of suicide
35 prevention.

36
37 In working with many of their patients who had intense
38 suicidality and working up ways to prevent suicide, the
39 three psychiatrists observed the intense pain that a person
40 was experiencing in suicidal crisis and was a motivator to
41 end one's life. In fact, Ed Sniedman termed the phrase,
42 psych-ache as a way of explaining the depth of the pain
43 experienced. And in his seminal text, Suicidal Mind went
44 on to explain the notion of psych-ache.

45
46 As we see in other forms of human suffering, we want
47 to reach out on a humanitarian basis, so we do in suicide.

1 The person who is in such profound pain and despair, we
2 need to reach out to them on a humanitarian basis.

3
4 Q. Is that not the way suicide prevention is being done
5 at the moment?

6 A. I think you will find that many of those who are
7 working in suicide prevention absolutely approach suicide
8 from that angle. From my own personal experience as a
9 volunteer on the phones with Lifeline at one stage and
10 through my work with that organisation, I know of the
11 thousands of people who have answered calls or worked in
12 communities and in other organisations motivated by that
13 desire to simply reach out compassionately to help another
14 human in need.

15
16 But it's not as easily the case in our policy and
17 institutions or our societal attitudes. We might be
18 mindful that it's only been a matter of 40 plus years in
19 Australia since suicide no longer became a crime under
20 State law. We reflect that there are still some attitudes
21 towards suicidal people, that they're attention seeking or
22 selfish, grossly misguided understandings, and that
23 sometimes suicidal people do not receive attention and
24 compassionate responses from health professionals and
25 others.

26
27 There is still something of a stigma and there's still
28 the mythologies surrounding suicide that exist across our
29 society, yes.

30
31 Q. If this approach is taken, a more compassionate
32 approach, what do you see the implications of that approach
33 being?

34 A. Well, part of the implication is that it underpins our
35 motivation and our belief that suicide is preventable.
36 Because, once we understand that the experience of feeling
37 profoundly suicidal or a suicidal crisis, is a person's
38 response to what is happening in their life and to how they
39 are, then we don't so much place a blame on the person or
40 seek for oversimplistic solutions to their despair; we
41 start to approach the issue in a more informed and
42 realistic manner, that it's a complicated human behaviour
43 for which a multi-factorial and consistent response is
44 required.

45
46 Q. I will come back to the multi-factorial consistent
47 response but I want to ask you some more questions before

1 we get there. Can we turn to the issue of the overlap
2 between suicide and mental illness. You said in your
3 statement:

4
5 "Over the last 5 to 10 years we have seen
6 changes in this discourse across both the
7 research community and the suicide
8 prevention field. There is now a broad
9 recognition that while mental health may be
10 a factor in suicidal behaviour, it is not
11 the only factor and it may not even be the
12 primary factor. Suicidal behaviour is
13 formed from multiple factors, rarely one
14 single factor."

15
16 Can you explain to us the shift in the learning from
17 what it was to what it is now?

18 A. Yes well, 100 years ago or even 50 years ago it was
19 not uncommon for the prevailing view to be that the person
20 who dies by suicide or becomes suicidal must be profoundly
21 unwell, they must have mental ill-health; why otherwise
22 would they want to end their life?

23
24 That has to some extent been validated in research
25 studies using psychological autopsy methods which are
26 sought to examine hundreds or thousands of deaths by
27 suicide to see if a clinical diagnosis of mental ill-health
28 could be prescribed. So, for many years that was the
29 prevailing wisdom and a research community generally
30 thought that it might be upwards of 75 per cent,
31 80 per cent, 85 per cent, of those had died by suicide
32 would be clinically diagnosable with mental ill-health at
33 the time of death.

34
35 More recently there's been a greater understanding to
36 question the methodologies around psychological autopsies
37 perhaps not being as reliable as earlier thought, but other
38 data sources have also come to question that outlook. Most
39 notably, where we have had data on people's use of mental
40 health services in the 12 months prior to their death, it's
41 become apparent that while maybe 40 to 50 per cent of those
42 who died by suicide have had some contact with mental
43 health professional, similar proportions may have had
44 contact with other forms of services, social services or
45 the justice system, straight away suggesting that there are
46 other facets of things happening in their lives.
47

1 Moreover, some of the more recent research analysis
2 has identified comorbidity issues particularly around
3 substance abuse and alcohol abuse, and also underlying
4 factors such as the experience of early childhood neglect
5 or abuse. In more recent times a greater understanding to
6 some of the situational factors or negative life events
7 that might influence a person's suicidality.

8
9 So, while we would not dismiss the place of mental
10 health in suicidal behaviours, we have a much better
11 understanding nowadays that it is a multi-factorial
12 behaviour of which mental ill-health may be a contributor.

13
14 Q. Can you just clarify for us, what's a psychological
15 audit? What does that involve?

16 A. A psychological autopsy.

17
18 Q. Autopsy, sorry.

19 A. Yes, so it's a research method that looks at the
20 information and data held of those who have died by
21 suicide.

22
23 Q. You've also said:

24
25 "For some people mental health illness is a
26 significant factor in suicidal behaviour."

27
28 Can you expand on that, when is mental illness a
29 significant factor?

30 A. Well, it can indeed be, and there are two ways of
31 looking at this situation: on one hand those with prevalent
32 disorders such as depression and anxiety may be over
33 represented in suicide deaths by more than double. On the
34 other side of the coin, it is estimated that less than
35 5 per cent of those with mood disorders die by suicide.
36 So, it's an issue, but it's not the only factor.

37
38 Q. And so, ultimately you've said:

39
40 "We need to be careful in ascribing a
41 causal relationship between mental illness
42 and suicide."

43
44 A. We do need to because sometimes it reflects some of
45 those stigma-related attitudes and it can unfortunately
46 lead to us, in a service and policy response, feeling that
47 if we just give our attention to those who are mentally

1 ill, we will solve the problem of suicide. Well, suicide
2 is not that straightforward in the same way if we said
3 there was any other single factor that we wanted to ascribe
4 simple causality to suicide, we would be ultimately not
5 effectively understanding the issue.

6
7 So, yes, we need to give attention to mental health,
8 and at a population level it's always good to have a more
9 mentally healthy population that in itself will serve as a
10 suicide prevention measure, but we also need to understand
11 that there are many factors that might be behind a person's
12 suicide.

13
14 Q. In terms of the mentally healthy population you've
15 said:

16
17 "From a public health perspective efforts
18 to improve the overall mental health and
19 wellbeing of the population will generate a
20 commensurate reduction in suicidal
21 behaviour."

22
23 Can you expand on that, and you gave the example of
24 the European Alliance Against Depression; can you explain
25 what they've done in relation to suicide prevention?

26 A. Yes, certainly. I guess as a general point, a
27 mentally healthier population will have many benefits,
28 including clearly the participating lives and the enjoyment
29 of life and quality of life of the population, so in that
30 sense it's something to pursue as an end in itself.

31
32 But we also have a better understanding nowadays of
33 the economic and social benefits of a mentally healthy
34 population.

35
36 With regard to suicide, there are certain protective
37 factors that are generated through enhanced mental health.
38 Sometimes the term "resilience" is used, and perhaps that's
39 an angle, where a person is better equipped to roll with
40 what life throws at them and to make decisions or solve
41 problems. Sometimes the aspects of being more mentally
42 healthy mean that you are also going to be able to exercise
43 self-care and therefore attract the protective factors
44 yourself through lifestyle choices through what life
45 opportunities bring.

46
47 The European Alliance Research is an interesting one

1 in point because it documented how investments in several
2 European studies, notably in Nuremberg which sought to
3 advance population level outreach and utilisation of
4 services to reduce depression found that there was a
5 commensurate reduction in suicide. In the Nuremberg study
6 it was in the order of a 17 per cent reduction at the time.
7

8 What it points to is that there are some service
9 systems and some community outreach around mental health
10 that can be highly beneficial. In Australia, we have
11 pursued some of this through initiatives to reduce the
12 stigma around help-seeking to do with mental health and
13 promotion of understandings around prevalent mental health
14 issues such as anxiety and depression. So, those things do
15 have a positive impact, absolutely.
16

17 Q. You mentioned earlier the issue of comorbidity. Why
18 do we need to focus more attention on comorbidity issues?

19 A. Well, it raises a better understanding of what might
20 be underlying suicidal crisis, but the most practical
21 reason for looking at comorbidity is, it drives what sort
22 of services and strategic responses we need.
23

24 So, for example, the issue of alcohol and substance
25 abuse in suicidal behaviour is one where a mix of service
26 provision across mental health, drug and alcohol services
27 and other community services is going to be fruitful, and
28 yet, that's one of the areas where often in our service
29 system with we struggle: we create demarcations or
30 different pathways and routes to service responses that are
31 not connected, and therefore, the person who is
32 experiencing a range of factors that are affecting their
33 wellbeing and their suicidality is getting a poorly
34 coordinated or if at times not coordinated at all service
35 response.
36

37 Q. You've mentioned in your statement that:
38

39 "Providers and professionals in the mental
40 health system need to be skilled to deal
41 with suicidal behaviour and to contribute
42 linkages with other services and support."
43

44 Which is again what you mention with the comorbidity.
45 Can you expand on that and how we ensure those providers
46 are skilled in that way?

47 A. Again, there's a couple of layers there. First and

1 foremost my point is that those who are working in the
2 professions to do with mental health need to have a level
3 of basic understanding around suicide and suicidal
4 behaviour and be equipped with skills so they are competent
5 to recognise where a person is recognising suicidality and
6 respond effectively, and that requires large scale
7 universal training of health professionals.
8

9 For example, one of the training programs, there's one
10 known as Connecting With People which has been utilised in
11 South Australia and now Tasmania is an example of how a
12 relatively short training program can equip people to a
13 basic level of appropriate responses should one of their
14 patients or clients indicate being suicidal.
15

16 There are also some aspects around service design and
17 service delivery where linkages can be formed. So, for
18 example, the linkages between the health services and
19 services to do with a person's economic or social
20 wellbeing; the ability may be to link health services with
21 employment services and to have more flexible and creative
22 ways of creating models for people to access employment
23 linked to their treatments and care for mental health
24 issues.
25

26 There was perhaps an understanding by some that those
27 with mental ill-health are not able to work, and that
28 attitude almost takes us off the collective hook of finding
29 work and encouraging work for people. Well, the voice of
30 those with lived experience of mental health issues is
31 often that work is one of the great protective factors and
32 there's a straight economic benefit there too and it allows
33 a person with a high level of self-sufficiency and the
34 ability to make some decisions in their own lives, so I
35 would say that would be one example where strong linkages
36 and finding models of service and ways in which those areas
37 of employment and health can complement each other and be
38 effective.
39

40 But there are others: housing is another one and I've
41 named the issues of alcohol and substance abuse.
42

43 Q. Can I turn to the issue of global best practice.
44 You've stated:

45 "There is one key dossier on global best
46 practice of the evidence the effective
47

1 suicide prevention and that's the WHO 2014
2 Report Preventing suicide: A global
3 imperative."
4

5 First of all, why is that the one key dossier, why are
6 you pointing to that particular document?

7 A. Yes, I think it's one the key documents because it
8 brings together the collective research and expert
9 knowledge from around the world in the field of suicide
10 prevention in one document. So, I often have said to
11 people, "if there if there's a one thing you're going to
12 read, that's a good one to read".
13

14 It's also relatively current, it was released in 2014,
15 and it includes many of the current directions in suicide
16 prevention.
17

18 The other reason I think it's so important is, it
19 translates the evidence from the research community along
20 with the expert knowledge and that of people with lived
21 experience into quite specific recommendations around
22 national strategies for suicide prevention and the elements
23 that should be contained in those strategies, and the
24 design of sound public policy and program development in
25 suicide prevention, so it's a very helpful document indeed.
26

27 Q. What are the key recommendations from that document?

28 A. The key recommendations are, firstly, that suicide
29 requires a multi-factorial strategic response, and it
30 outlines the case for that and puts forward the
31 architecture for effective national suicide prevention
32 strategies.
33

34 The other I guess recommendation of note in that
35 report is that it recommends that nations take up sustained
36 effort in a coordinated fashion for suicide prevention. In
37 other words, there is no single solution, there is no
38 simple way to reduce suicide; it requires diligent,
39 consistent and concerted effort over time, and the report
40 lays out where the efforts should be going.
41

42 Q. The Fifth National Mental Health and Suicide
43 Prevention Plan, the Australian document, is based on that
44 WHO model; is that's right?

45 A. Yes, they've recognised the WHO report. Indeed,
46 Australia is a member nation of the World Health
47 Organisation, so we have both contributed to that report

1 and we are responsive to that report.

2

3 Q. And then also, the Victorian Suicide Prevention
4 Framework is also informed by the WHO report; is that
5 right?

6 A. It is, in perhaps a less than direct way, in that it
7 has been the case for more than 20 years in Australia but
8 the national suicide prevention frameworks have been
9 mirrored by state and territory governments. So, that
10 generally relates to what are called the national mental
11 health plans and in the last iteration is now the National
12 Mental Health and Suicide Prevention Plan.

13

14 Q. At the Victorian level, are there any elements from
15 the WHO report which warrant more attention in Victoria?

16 A. At the strategic level, no; the Victorian Suicide
17 Prevention Framework does refer to the key elements that
18 are within the WHO framework. Where the issue lies in
19 Victoria in my view is more around its translation into
20 policies and programs and services where there could be
21 shifts in emphasis, yes.

22

23 Q. Can you give an example of that of where you see that
24 there's potential for a shift in emphasis?

25 A. Yes, the one that I would give as an example is in the
26 area of crisis response and aftercare. I should hasten to
27 say that Victoria is not greatly different to other States
28 and Territories in Australia, and that nationally this is
29 an area that we have not invested and undertaken as much
30 efforts in the past as we could have.

31

32 By crisis response and aftercare, I'm referring
33 directly to how we identify and respond to people in
34 suicide or in crisis, and ensure that there is a follow up
35 support and the offer of services and programs to assist
36 recovery beyond the crisis. Most practically, that can
37 occur through things such as hospitals where people who are
38 in suicidal crisis may appear, but it also might strengthen
39 linkages with services such as help lines to which a
40 proportion of people in crisis will go, and also linkages
41 into community supports where people may be visible in
42 crisis. There needs to be more investment in the response
43 at the time of crisis and the progression into aftercare
44 and recovery programs.

45

46 Q. You also identified another area for improvement is a
47 properly structured, resourced and planned regional

1 approach to suicide prevention. Can you explain what
2 exists now and what is needed to get that more structured
3 consistent regional approach?

4 A. Yes. Drawing back to the WHO report for a moment, one
5 of the things that was found there is that there are indeed
6 geographic differences in suicidal behaviour and suicide
7 rates around the world. Within Australia, as a large
8 country with a population spread across a sizeable land
9 mass, there are has notable differences in geographic or
10 regional factors surrounding suicide and suicidal
11 behaviour. Those factors may differ along the lines of the
12 demography of the population, including ages, the economic
13 base of the regions, and social factors including the
14 social capital of regions.

15
16 So, it is a national priority under the Fifth Plan for
17 there to be regional approaches to suicide prevention, and
18 in Australia the recent national reforms to establish
19 primary health networks with the mandated role in suicide
20 prevention has strengthened that.

21
22 For Victoria, as with other states, there is the
23 opportunity to build and strengthen regional approaches to
24 suicide prevention so that regional plans are responsive to
25 regional factors, and also, so that service networks and
26 program activity is strengthening regional strengths but
27 also addressing where there may be issues within regions.

28
29 So, this is an area that I believe Victoria can and
30 should do more in. I would use the example of South
31 Australia, where there has been a state-led investment in
32 regional suicide prevention networks being created which
33 are required to be supported by the regional health
34 agencies and also mandated to include local government as
35 well as community representatives and community services.

36
37 That model in South Australia is providing them with
38 infrastructure that they can invest dollars into for
39 education, training, service development, better
40 coordination, effectively building the capacity for suicide
41 prevention across the state through those regional
42 networks. Victoria could do likewise, I believe.

43
44 Q. That doesn't exist in Victoria at present?

45 A. It doesn't exist on a comprehensive basis. Victoria
46 presently is showing leadership and responsiveness to the
47 issue of suicide prevention through the so-called HOPE

1 Trials which were addressing the crisis response and
2 aftercare, and the so-called place-based trials which are
3 recognising the importance of regional approaches.
4

5 My observation, however, is that, while you're in a
6 trial period and there may be things learnt from that,
7 there is a need for there to be a policy, funding and
8 program commitment to the implementation of those models
9 after the trial period ends so that they become business as
10 usual across the whole state of Victoria, not just trials
11 that happen in particular areas.
12

13 Q. So, do we not have that policy funding and evaluation
14 for those trials as far as you're aware?

15 A. I think that's more a question really for those in
16 government and the relevant agencies to be answering, but I
17 certainly would make the observation that it is an
18 important step to be taking in the future for improved
19 suicide prevention in Victoria to address those two areas
20 which are currently under trial.
21

22 Q. In terms of people who are at risk of suicide, are you
23 able to identify any particular cohorts who are at
24 increased risk of suicide?

25 A. Yes, there are various ways we can identify those who
26 have a greater vulnerability on the basis of statistics.
27 Australia is quite fortunate to have data relating to the
28 profiles of those who die by suicide. Victoria is, in
29 particular, very fortunate to have the Victorian Suicide
30 Register through the Coroners Court system here; there's a
31 very significant database that can provide those insights.
32

33 But, broadly speaking, we do know for example that men
34 represent three out of four deaths by suicide in Australia,
35 so there is a gender-based issue around suicide deaths in
36 Australia as there are in most western countries.
37

38 We also know that indigenous people are represented at
39 twice the rate nationally in suicides, and some indigenous
40 communities have some of the highest suicide rates in the
41 world.
42

43 There are other groups in our population that are
44 vulnerable, LGBTI groups, people living in farming and
45 farming communities, certain occupational groups such as
46 construction workers. So, the data is there for us to use
47 and it does help us inform where, on a prioritisation

1 basis, we might want to put effort.

2
3 It also highlights to us that there are differences
4 across populations and sub-populations, occupational
5 groups, social groups in our community, so there is not a
6 one size fits all program or service response in suicide
7 prevention. We must make efforts to reach out to people in
8 their differences, knowing that some of those differences
9 may in fact be some of the factors that we need to give
10 attention to for suicide prevention.

11
12 Q. Given we have all this knowledge at this point, and
13 the data and the suicide prevention and the Suicide
14 Register, why is it that Victoria has not been able to
15 reduce the suicide rate?

16 A. Well, I think it is worth making the point at first
17 that Victoria has had a lower than national suicide rate
18 for the last 10 years, and in the last reporting year of
19 2017 was the only state in Australia that saw a reduction
20 in the numbers of deaths by suicide. So, I would want to
21 put that out firstly just to say, it's not as though
22 nothing's working; there are some things clearly that are
23 working in Victoria around suicide prevention.

24
25 It's also the case that across Australia and many
26 other western developed countries, such as Rotorua in
27 New Zealand, Canada, the USA, there have not been marked
28 reductions in suicide rates over the last decade. In
29 Australia the suicide rate has increased slightly in
30 recent years, which is of great concern.

31
32 There is no single reason for this, and it's highly
33 perplexing for Australia, which as a country by and large
34 has had a very stable and productive economy, we have had
35 no internal wars or internal social unrest, and we have not
36 had impacts on our population which other countries in the
37 world have, we've been a fortunate country in many
38 respects. So, there's nothing clearly that stands out to
39 say why the suicide rate may have stayed the same or
40 increased slightly.

41
42 To me, it's more about the execution of our strategies
43 in a coordinated and deliberate way and ensuring that all
44 elements of the strategies are highly performing in the way
45 they should. So, to me it's more a question of management
46 and implementation of the knowledge that we have, than it
47 is about any particular factor or knowledge gap.

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Q. With the strategies that we are using, are they being monitored and evaluated to ensure they're operating as they should? What do you mean by that?

A. Well, again, coming back to the WHO framework with the 11 components for an effective strategy, there are some things in Australia that we've done very well. For example, our media reporting around suicide has been significantly moderated over the last 10 or 15 years with the influence of the Mindframe program, so our media reporting around suicide incidents and suicide generally is safe and appropriate. Now, that is a real strength and that is undoubtedly contributing towards reduced suicidal behaviour and deaths.

But in other areas, such as the crisis response and aftercare, we have done less and some of that will require reforms to our service systems and will require longer term funding commitments to programs and services and continued action so that they're not just isolated services in some areas and not in others

As I said, I think it's more a question of us having the comprehensive approach well executed across programs in a coordinated way with the level of resources required and the consistent effort required.

Q. Is it possible to evaluate the effectiveness of those kind of programs within the systematic model?

A. I believe it is, but I think it's something that we still need to work on. We do tend to draw judgments around the effectiveness of our suicide prevention programs and services based on very high level measures of the number of deaths by suicide or the prevailing suicide rate. And yet, one of the things that we know about a complicated human behaviour such as suicide is that, most likely no single service or program is going to make a huge impact on the national suicide rate. The difference to the suicide rate nationally will be made through a multitude of programs and services working strongly together against a solid strategic framework.

What I think we may need to do in the future is put more effort into identifying the measures of those individual programs and services so that they can be examined for performance and accountability on what they can reasonably contribute.

1
2 If I can give you the example the Mindframe program
3 and the media coverage. That program can be assessed for
4 its effectiveness and performance in light of how media
5 coverage occurs in Australia, the knowledge base of
6 journalists and those working in the media around suicide
7 and suicide prevention; those are measures that we can
8 attribute to that program. We would not want to say that
9 the Mindframe program is solely responsible for the
10 national suicide rate, but we can say that it is a program
11 should be accountable for influencing the quality and
12 safety of media reporting on suicide.
13

14 Q. Still on this issue of measures to work out what's
15 effective, do the measures exist for other programs? So,
16 for crisis response and aftercare, do those measures
17 already exist or do they need to be developed with the
18 appropriate programs being developed?

19 A. To some extent they exist but more can be done in that
20 regard. So, some programs have established measures that
21 are workable and can be reported against, and for many
22 others there's not. There was an evaluation of the
23 National Suicide Prevention Strategy done several years ago
24 and one of the findings from that evaluation was that,
25 while dozens of projects or services had been supported
26 through the National Suicide Prevention Program, most of
27 the evaluation data was activity based: how many people
28 through the service, how many activities occurring within
29 the service and very little in the way of effectiveness
30 evaluation.
31

32 Q. Still on this issue of how suicide prevention should
33 be measured, your view is that the suicide rate is not the
34 single appropriate measure; is that correct?

35 A. It should not be the only measure. It's one, and it's
36 a useful one, but it's not the only measure. I think that
37 there are a couple of ways of looking at this issue. If I
38 maybe preface my comments by saying, I've worked in
39 evaluation for many years and, one thing that marks better
40 evaluation is where a variety of data sources are drawn on
41 informing the evaluation conclusions. Suicide is such a
42 complicated area of activity to evaluate suicide
43 prevention, we need to look at more than one set of data.
44

45 If I could highlight one data source which is more
46 approaching the question of suicide prevention from the
47 population's perspective, and that is to look at measuring

1 and monitoring a national or statewide levels of underlying
2 suicidality and suicidal behaviours. That was last
3 reported nationally in 2007 through the ABS National Mental
4 Health and Wellbeing Survey and provided useful insights
5 into the underlying proportion of Australian population
6 that expressed that they had in the last 12 months
7 experienced suicidal ideation; the proportion that had
8 taken suicidal action, such as an attempt on their life,
9 and that was the last time that survey was undertaken.
10 That, to me, is an example of important data to be
11 monitoring because our efforts for suicide prevention
12 should be seen in shifts around the underlying population
13 levels of suicidality and suicidal behaviour.

14
15 Q. In relation to the limitations on the data that are
16 currently available, the ABS survey is obviously one
17 example that was conducted a while ago now. Are there
18 other limitations on the data that's available that are
19 hampering effective suicide prevention measures?

20 A. Yes, there are other areas that we could make
21 improvements, notably through the hospital and health
22 systems. So a proportion of people in suicidal crisis and
23 those who attempt to end their life will become visible to
24 the hospital and health systems, possibly through their
25 presentation at Accident & Emergency because of the injury
26 or their health issue; possibly through other areas of the
27 health system.

28
29 But we do not have in Australia a consistent way of
30 identifying and reporting, or coding, for suicide
31 presentations. We use a definition around intention of
32 self-harm which may or may not include suicidal behaviour
33 and intent, and we have no consistent way of reporting on
34 that and viewing that, aside from highly retrospective
35 reports done by the Australian Institute of Health and
36 Welfare.

37
38 Q. Are there any impediments to developing a consistent
39 model of trying to obtain that data?

40 A. Well, it requires a system reform and it requires
41 resources, so in view of other things where you want to
42 collect data and to do it consistently and usefully, it
43 requires people to have the system to do that, to be
44 trained and required to do that and to be accountable for
45 it and for the data to be reported.

46
47 Q. But, do we have the knowledge at this point in time to

1 input into that system reform, or is there still a
2 knowledge gap?

3 A. There'd be a bit of developmental work to obtain
4 consensus around the coding and the definitions, but I
5 think we have the knowledge that would allow us to do that,
6 yes.

7
8 Q. Finally, Mr Woodward, are there any initiatives or
9 ideas that you think could be implemented especially in
10 relation to the concept of distress and human suffering
11 that are not already being implemented in the field of
12 suicide prevention?

13 A. Well, I think one of the things that is so important
14 is to understand the value of connection and compassion in
15 suicide prevention. So, we can look at, I guess, the more
16 technical aspects and the service responses, including
17 clinical treatments and a whole range of things, but there
18 is a real need for services and community responses to
19 encourage connection between people so that no-one is left
20 feeling alone in their suicidal crisis and to encourage a
21 compassionate response to understand the suicidal crisis as
22 a story of human suffering.

23
24 Now, some of that can come through the formal service
25 system, and we would hope that health professionals, social
26 workers, mental health nurses, people from related
27 services, government officers, would be equipped to provide
28 that level of basic compassionate response and
29 understanding, or at least not create problems for the
30 suicidal person and their carers.

31
32 But there's also a need for our response in suicide
33 prevention to see better linkages between what I'd call the
34 community support system with the service support system.

35
36 Back to the statistic I mentioned, maybe half of those
37 who have a suicidal crisis present to the health and
38 hospital system. Half do not. Research that was
39 undertaken a couple of years ago now, known as the Care
40 After Suicide Attempt Report through the Black Dog
41 Institute, the report provided to the National Mental
42 Health Commission, a survey research involving more than a
43 hundred people who have survived a suicide attempt, asking
44 them what was their experience of service responses, where
45 did they go and what did they need. One of the most
46 frequent dissatisfaction they had with service responses
47 was the failure of the service responses to address their

1 emotional support needs.

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Now, at one level we should be pleased that our health services are able to respond to people's clinical and medical needs very well in this country - we're fortunate. But in suicide prevention we also need to ensure that there are community supports and services that address the emotional support needs.

We fully recognise that the emergency nurse in the A and E is probably not able to do much of that, so the linking into the community support services is so important as part of the reform of the service system.

And more widely across the mental health system, the personal and emotional support needs for people struggling with mental ill-health is often identified by those with lived experience as one of the key gaps in the system.

So, in my view, one of the critical reforms is to strengthen the linkages so that the person who's appearing before hospital is able to have a pathway created also for a non-formal, non-professional services support.

MS BATTEN: Thank you, Mr Woodward. Chair, are there any questions of Mr Woodward?

COMMISSIONER FELS: Q. Thank you for your very excellent evidence. Do you see any value or otherwise in setting goals for reducing suicide? There is of course a fair bit of talk about halving it and reducing it to zero and so on. A. No, I don't. I think an aspiration to prevent suicide in itself is sufficient because, as I mentioned at the start of my evidence, none of us want to see preventable deaths occur. We are all motivated to value each and every one's life, but I'm not in favour of setting targets or goals for suicide prevention for a couple of reasons.

The first one is probably a technical reason: is, I just have not seen a methodology that can reliably create an estimate that you could work to, and in management theory there's no point setting goals that can't be substantiated.

Now, the WHO report indicated loosely a 10 per cent goal for all member nations, but that's not scientifically formed, that's an aspiration that they set. Others have

1 sometimes come up with 20 per cent or 50 per cent, but
2 there is no methodology sitting behind it, so from a
3 technical point of view I'd question the value of trying to
4 set a target where there's no methodology that can sit
5 behind it.

6
7 The other reason I'm not keen on setting targets or
8 goals in suicide prevention is more around the messaging.
9 And, I understand the motivation of setting targets in
10 human achievement, and in many areas of human achievement
11 that's a good thing to do, but to set a target of say
12 50 per cent in suicide prevention possibly carries with it
13 the unintended message that 50 per cent of those deaths
14 don't matter. And it doesn't say much for the person in
15 suicide crisis who hasn't died or their carers and family
16 members. It becomes too mechanistic in an area that is
17 profoundly requiring a humanitarian response.

18
19 Q. Secondly, you just mentioned in passing the data
20 suggests Victoria has a lower rate than other states. Are
21 there possible demographic explanations such as smaller
22 Aboriginal population, maybe fewer people in the farm
23 sector and things like that that could explain why Victoria
24 has better results?

25 A. Quite possibly all of those things may be contributors
26 to that. Interestingly, the states and territories that
27 have the highest suicide rates in Australia: Northern
28 Territory, yes, has a high indigenous population
29 proportionately; it also has some issues around alcohol
30 abuse and not only in indigenous populations.

31
32 Queensland, which has had increases in its suicide
33 rate, notably has a very high proportion of people dying by
34 suicide in rural and remote areas, and some particular
35 issues affecting farming communities.

36
37 Western Australia, which has had some increase in its
38 suicide rates in recent times: the commentary is that
39 perhaps that was related to some economic shifts in the
40 volatility of some industry.

41
42 You know, I think there are always plausible comments
43 that can be made. I would still go back to the base
44 comment I've made, and that is that suicide is a
45 complicated phenomena and it will be a complex mix of
46 factors that's occurring, so I'm a little careful about
47 making any broad statements around Victoria or other states

1 other than to say, we know there are some geopopulation
2 variances and some issues that each area of the country
3 needs to address.
4

5 Q. So, just on that very subjective general statement,
6 you've given us a picture of the complexity of it, the
7 nuances of what's been done and what might be done and so
8 on. I just wonder if a more general conclusion isn't
9 really available anyway, which is that, at the end of the
10 day we've not given it sufficient priority and that's why
11 we have this frustrating failure of the suicide rate to
12 decline, that in the bottom line, is that, had we given it
13 higher priority, we could have had a lower suicide rate?

14 A. Well, I think, yes, giving more priority is part of it
15 because priority in public policy terms is often reflected
16 in budgets, attention and reporting, all of which are
17 things that I would say are necessary.
18

19 I think, coming back to my statement earlier, however,
20 that I see it more as a matter of implementation and
21 management. I think there is a shift occurring where
22 suicide prevention in Australia is being seen increasingly
23 as a priority and that's to be welcomed. It reflects the
24 reality that the wider community knows that suicide is an
25 issue in our social fabric and it's affecting many people.
26

27 I think we have got very good knowledge and we have
28 far better, frankly than we've had for many previous
29 decades, understandings of the theories and frameworks for
30 effective suicide prevention, so to me mind it's more about
31 how we coordinate and implement and manage across a
32 multi-factorial strategy that will require linkages across
33 different portfolio areas in governments, will require
34 budget commitments that go beyond a three year cycle, and
35 will require some skill and capability and redesign efforts
36 in service provision.
37

38 COMMISSIONER FELLS: Thank you.
39

40 CHAIR: Q. I have two other issues I'd like to clarify,
41 the first of them relates to that issue of
42 whole-of-government really, what you're talking about
43 generally, a suicide prevention strategy requires a
44 commitment to a whole-of-government response multi-agency
45 but also with the added dimension of a high level of
46 community engagement. Is that correct from what you were
47 saying about lived experience et cetera?

1 A. Very much.

2

3 Q. Have you seen examples where that is working, in terms
4 where you genuinely get that commitment to a
5 whole-of-government, multi-agency community response?

6 A. Well, yes, I think we've done it in other areas in
7 Australia. The example that I would use would be around
8 road safety and the reduction of road accident deaths.
9 Which, you know, I grew up in the 1970s when seatbelt
10 wearing was optional, and the cars went very fast and
11 didn't stop very well and the roads weren't always very
12 good. As a nation we have come together, we've created a
13 National Road Safety Strategy that is then implemented
14 through the various tiers of government, from State
15 Government through to local government. We've got
16 investments in research and technical knowledge on road
17 safety, improvements in car design and road design. We
18 have strategic priority setting around black spot road
19 remediation works, we have community-based education, we're
20 starting from primary school age through, we engage the
21 community in the quest for road safety. We have driver
22 education, we have all these things occur, and low and
23 behold we've reduced the death numbers in the road accident
24 area by more than a half.

25

26 You know, we can do it and Australia can do these
27 things very well, so in that sense I find myself agreeing
28 with Commissioner Fels, that there is a measure of simply
29 putting the priority and focus to the task, but there are
30 some techniques that I would describe as good public sector
31 management and good engagement with the community, because
32 it's not all about government. You know, the government
33 can't do everything.

34

35 Q. Thank you. One other issue I just want to touch on in
36 your submission you said, when you were talking about what
37 the trends had been in relation to suicide, there was an
38 increase in suicidal behaviour in young women across the
39 nation, and you referenced an Orygen study that had
40 reported on that. Can you just elaborate further for us
41 about what might that have illustrated, or requiring
42 further attention?

43 A. Yes, well, the Orygen report is noted where we have
44 had data around presentations on self-harm through the
45 hospital and health systems that there have been an
46 increase in activity through predominantly young women.
47 Now, I don't think we fully understand what that is about

1 and why. Perhaps those who are working closer to the
2 frontline on that would have some insights.

3

4 But to me it's an example of where we are monitoring
5 the data on a much tighter timeframe we might be able to
6 make program and service responses, including community
7 responses, for suicide prevention.

8

9 CHAIR: Thank you. Thank you very much.

10

11 MS BATTEN: Thank you. May Mr Woodward please be excused?

12

13 CHAIR: Yes, thank you very much for your comprehensive
14 and very informative overview, Mr Woodward. Thank you.

15

16 <THE WITNESS WITHDREW

17

18 MS BATTEN: Thank you. There are no further witnesses for
19 today, may we adjourn till tomorrow?

20

21 CHAIR: Yes, thank you.

22

23 **AT 3.05PM THE COMMISSION WAS ADJOURNED TO**
24 **TUESDAY, 23 JULY 2019 AT 10.00AM**

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