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

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

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

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

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

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

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

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

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

immediate term.

There are often multiple reasons that lead a person to decide that ending his or her life is the only choice. Risk factors described in relatively academic terms are these, or include: socio-demographic factors, for example, men are at greater risk than women. Clinical factors: having a mental illness or having made a previous suicide attempt, neurobiological factors; situational factors, such as stressful life events; trouble with the police; alcohol and other drug problems. Access to harmful means is also a risk factor.

As to risk factors, the evidence is that suicidal behaviour is related to but distinct from mental illness. There's now a broad recognition that, while mental health may be a factor in suicidal behaviour, it's not the only factor and it may not even be the primary factor.

A broad understanding of the risk factors, however, is not enough to allow anyone, be it family, friends or clinicians, to predict who will attempt suicide and, if they do, when an attempt will occur. That's why the leading suicide researchers consider that the best approach to suicide prevention is one that includes three kinds of interventions.

First, universal interventions, which are those measures aimed at a population. They include measures to improve wellbeing at a population level and at this point we are reminded of the evidence that Professor Helen Herrman gave right at the beginning of the hearings about the importance of taking a population approach to wellbeing.

Universal interventions also include preventing or restricting access to harmful means in public or publicly regulated spaces.

Second, selective interventions, which are those means that target people in the population who are not actively suicidal but who have recognised risk factors for suicidal thoughts and behaviour.

Third, indicated interventions which reach individuals who are already having suicidal thoughts or engaging in suicidal behaviour. One opportunity for such intervention

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ms Batten will call the first witness.

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

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

MS BATTEN: Q. Thanks Rod. Have you, with the assistance of the Royal Commission's legal team, made a witness statement for the Commission?
A. I have.

Q. I tender that statement. [WIT.0001.0042.0001] Rod, could you please start by saying why you wanted to come and give evidence today?
A. Yeah. My evidence today is to prevent someone else going through what I have done, and try and put it out there that there's more help, but not enough help, out there for people considering what I went through from when I lost my job back in 2009/2010.

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.

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

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

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

Q. You're fine, just take your time.
A. Our local Shed in Sunbury has a total of 92 members, and I love all of them. When I joined the Men's Shed, I actually ended up on Who Wants to Be a Millionaire. We were able to win some money, a good amount of money, on that program to buy us another house in Sunbury.

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

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

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

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

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

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

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

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

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

I have a good counsellor that belongs to the Sunbury

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CHAIR: Yes. Thank you very much.

<**THE WITNESS WITHDREW**

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

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

MS NICHOLS: Q. Mr Dwyer, are you the manager, Suicide Mental Health and General Investigations with the Coroners Prevention Unit at the Coroners Court of Victoria?
A. Yes, I am.

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

A. Yes.

Q. Have you prepared a statement and a report about suicide and mental-ill Health in Metropolitan Melbourne and in Regional Victoria?
A. Yes, I have.

Q. I tender that statement with the attached report. [WIT.0002.0019.0001] Mr Dwyer, what's the Coroners Prevention Unit within the Coroners Court of Victoria?
A. The Coroners Prevention Unit is a specialist unit within the court that assists Coroners with their investigations into external cause deaths, particularly preventable deaths, and provides evidence and material and advice on opportunities to prevent these deaths, as well as maintaining a range of databases to develop the evidence base further to identify opportunities for prevention.

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

Q. Is it the most accurate and timely source of detailed information on suicide in Victoria?
A. I believe that it is. In terms of timeliness, we run what's called prospective surveillance on all deaths reported to the Victorian Coroner, and under the Act a suspected suicide is required to be reported. So a prospective surveillance program is that we will look at all deaths that are reported every day and will identify suspected suicides among them and add them to the Suicide Register as they occur. We've gone back and looked at the accuracy of our identification over time, and between initial identification and final confirmation from Coronial investigation, we're between 96 and 98 per cent accurate.

Q. One of the things you've said in your statement is that the dataset in the register is maintained prospectively, meaning that the suicides are monitored in near real-time?
A. That's correct.

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

A. As I just explained --

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

Q. No problem. So, maintaining the dataset prospectively and monitoring suspected suicides in near real-time; can you explain what is meant by that?
A. So, in terms of prospective surveillance, maintaining the data prospectively, we will add new suspected suicides to the database on a daily basis and we'll add certain information including sex, age, location of usual residence, location of fatal incident, method and so on, so that we can get an idea of what's happening with suicide as it occurs in Victoria.

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

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

Q. I might just stop you there and take you back a little bit. Let's focus on what the Suicide Register contains. So, does it have two datasets starting with a core dataset?
A. That's right.

Q. Just explain in simple terms, maybe slowing down again, what the core dataset covers?
A. The core dataset includes basic information about deaths reported to and investigated by Victorian Coroners. So, it includes, for example, sex and age of the deceased, location where the suspected suicide occurred, the location where the person usually resided, and the suicide method and, when it's confirmed, the Coronial cause of death.

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

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

Q. Broadly speaking, how is that information gathered for the purposes of putting it into the enhanced dataset?
A. We have trained coders who review the full Coronial brief and all of the material that's gathered for the Coroner's investigation and those coders will then enter the information, and we have a coding and quality manual, a quality process and so on to support that to ensure that the best possible and most accurate and complete information is entered.

Q. From an overarching perspective, what's the purpose of the maintenance of the Victorian Suicide Register?
A. Its primary purpose, the purpose for which it was first developed, was to assist Coroners with their investigations into suicide deaths, to answer questions for Coroners about the circumstances in which suicides occur and what opportunities there are for interventions. But other purposes have developed over time as well.

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

Q. Are there any noteworthy limitations on the data held within the Victorian Suicide Register?
A. Well, first, it needs to be recognised that we code

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

Q. You mentioned in your statement that the Coroner's Prevention Unit is working with DHHS and other partners on a data linking project to understand how people who die by suicide engage with public mental health services. Can you tell the Commissioners a bit about what that project is and what its purpose is?
A. I can describe it in quite general terms, but I should emphasise that the project is a DHHS funded and auspiced project, and our role in it really is the provision of data.

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

Q. I see. Can I ask you, moving from the register itself, for the purposes of it, how are suicide rates calculated?
A. So, the suicide rate, the reason why we're interested in rates is because you have your frequency of suicides, so the number of suicides that occur, and then you have for each person who suicides, they belong to different populations: by age, by sex, by their national identity, as Aboriginal and Torres Strait Islander people and so on. So, the reason why you look at rates, what the rate is basically is the frequency of suicides in a particular group divided by the population who belong to that group. The reason why we look at rates is so that we can see where there's a greater frequency of suicides occurring within particular populations.

Q. Are frequencies of less than 20 generally considered

unreliable where that is the frequency for a given population group?
A. Generally, but I should emphasise that I don't have a background in statistics or epidemiology.

Q. But that's the operating principle as far as you stand for the Victorian Suicide Register?
A. Yes, that's correct.

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

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

Q. Thank you. For the purposes of location-based suicide analysis, does the register record the location where the incident occurred and the location where the deceased usually resided?
A. That's correct.

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

Q. How is mental illness defined for the purposes of the Victorian Suicide Register?
A. We code two different sets of data on mental ill-health: we code where we have evidence of diagnosed mental illness according to the ICD-10, and that is where the material that's been gathered for the Coroners investigation indicates that the person had a formal diagnosis from an appropriate health practitioner.

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

Q. Does the Victorian Suicide Register include coded information on health service contacts for mental health-related issues within both six weeks of death and 12 months of death?
A. That's correct, yes.

Q. Does the Coroners Court hold data about the presence of mental ill-health in cases where the deceased has died by means other than suicide?
A. We do hold that information in some datasets that were put together for some projects. For example, we have that information for some overdose deaths and family violence-related deaths.

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

I should have asked you, you probably can't control it from where you are, can you?
A. I don't believe so.

Q. Perhaps we can ask for the next slide to be shown when you're ready, thanks, Mr Dwyer.
A. Okay, thank you. I'm really sorry, I should have done this at the beginning. I acknowledge the country on which we're meeting today, the Kulin Nations, and pay respects to any Elders past, present and emerging. And, thank you very much for inviting me to appear before the Royal Commission today.

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

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

Q. Mr Dwyer, you just take your time, you can relax, we've got plenty of time today, so just keep going.
A. With your leave, I'm happy to. Who's controlling, sorry?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Q. Thank you very much Mr Dwyer. Can I just ask you one question, and that is, what are the challenges involved in identifying at a more granular level those cohorts within the Victorian population who are at high risk of suicide?
A. That's an incredibly broad question. So, the question that comes out of it, this is just sort of basic information about suicide in Victoria, but what people really want to know is among all of these, are there particular groups, say particular cultural and linguistically diverse groups, or are there particular cohorts defined in a number of different ways who are at higher risk of suicide? And, we have two challenges in identifying those groups or calculating rates to say, yes, this group is at increased risk or, no, this group is not.

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

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

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

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

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

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

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

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

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

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

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

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

COMMISSIONER FELS: Thank you, that was very informative. A couple of questions that might be on the boundaries of what you want to talk about. To what extent is the issue of data a possible underestimate? It's probably not an overstatement of it, but there are some that you don't catch or don't come forward-looking like suicide et cetera. That's one question. Is there an understatement in these numbers of the number of suicides in the community?
A. We don't believe there is. So, all suspected external caused deaths are among the deaths that are required to be reported to the Coroner's court, and we run our surveillance process across all deaths that are reported, and we continually update our data as we learn more about the deaths.

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

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

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

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

Q. My second question was, and you've mentioned this, the Australian Bureau of Statistics published some numbers. Do you have any comments on the relationship of their data to your data?
A. I know that they use different methods, and for example, for us a year means a year, deaths reported between 1 January and 31 December in a year. But my understanding is that their definition of a year is slightly different: it's about when the case is initiated in their system or something like that.

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

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

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

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

LGA level with the place-based trials?
A. Yes we are.

Q. Also that in your longer report it indicates the huge variation which you described in the graph. So, how far can we think about or aggregate around particular communities, for instance, outer Metropolitan Melbourne versus inner Metropolitan Melbourne; larger regional centres and the associated LGA's around them? Is it possible for us to get to a meaningful set of data, understanding that it has to be meaningful, for us to draw any conclusions?
A. It's possible to generate the data, that's not a problem, but as to drawing conclusions, I mean, that's a matter for you - not being trite or anything. Basically, if you tell us what you want, then I think that we can aggregate the data, we have it down to suburb level; we actually have it down to street address level and then built all the way up to LGA level. So, yeah, we can combine the data geographically in any way that is requested.

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

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

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

CHAIR: Q. Thank you very much for the overview. There is one particular issue I wanted to also just clarify. Are you able to disaggregate the data by age cohorts in terms of their contact with the health services, both in the year and six weeks before the suicide? Because I was particularly interested in the 10-14 and 15-19 age group, whether there's any differences in their help-seeking contact?
A. Yes, we can definitely do that. But we also recently published a paper - I mentioned earlier that we collaborate

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

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

MS NICHOLS: May Mr Dwyer be excused, please?

CHAIR: Yes, thank you.

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

CHAIR: Yes, thank you.

SHORT ADJOURNMENT

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

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

MS NICHOLS: Q. Professor Pirkis, are you the Director at the Centre For Mental Health at the Melbourne School of Population and Global Health at the University of Melbourne?
A. I am.

Q. Do your research interests focus on the epidemiology of suicide, including the prevention of suicide at a population level?
A. They do.

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

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

prepared a statement addressing the questions we have put to you?
A. I have.

Q. I tender that statement. [WIT.001.0057.0001] Can I ask you about the risk factors for suicide. Firstly, from an epidemiological perspective in broad terms how are they calculated?
A. So, the best way to think about it perhaps is that epidemiologists would calculate the proportion of people who have died by suicide who have a particular characteristic or experience, and then compare that with the proportion of the population who haven't died by suicide who have similar characteristics and experiences.

Q. Broadly speaking, how are those characteristics associated with people who have died by suicide? What sort of investigations are done to establish that?
A. So, there are various different ways that epidemiologists and others would look at risk factors. Sometimes they do what they call psychological autopsy studies, so they would talk to the family members and friends of someone who's died by suicide and do comparable investigations with family members and friends of people who haven't died by suicide.

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

Q. In relation to the first type of investigation, questioning of family and friends of people who have not died by suicide, is that in order to establish a control group?
A. Yes, that's right. Obviously, they could ask the living people themselves about their characteristics and experiences, but there's a question about whether the kind of information they'd get would be equivalent. So, because the psychological autopsy studies are asking the family members and friends of the people who have died take that approach, they do the same with what they call the control group.

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

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

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

Q. You have personality-based, I think you've discussed that already. Situational environmental?
A. Sorry that's the last one, so situational or environmental risk factors which is an important one. Situational factors might be stressful life events. Environmental factors might be things like access to means.

Q. Do you also distinguish between proximal and distal risk factors?
A. That's right. So, people talk about proximal risk factors as being risk factors that occur close to the event. So, often they are stressors, recent stressful life events, and more distal risk factors that perhaps have been part of the person's life for a long time.

Q. How do proximal and distal risk factors interrelate in the case of any particular suicide?
A. So, often, but not always, as others have said, suicide is extremely complex and plays out differently for different people, but often the proximal risk factors would be the triggers or tipping point that might lead someone to make that decision at that particular point in time. Whereas the more distal risk factors are things that, I guess, perhaps people might say lay the potential for suicide.

Q. We'll come to interventions shortly, although not yet, but just this question: do suicide intervention strategies seek to intervene in relation to both proximal and distal risk factors?
A. Yes, absolutely. People talk about universal and selective and indicated inventions. The universal target the whole population without particularly trying to identify individuals in that population who might be at risk. Selective interventions target people who are showing some signs of the risk factors but not necessarily

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

Q. We'll return to that subject very shortly, but can I ask you about the relationship between mental ill-health and suicide. What does the research that you and one of your PhD students has recently completed show?
A. So, the PhD student is Angela Clapperton and she's a PhD student who co-supervised, and she did some work amongst other things using the Victorian Suicide Register.

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

Q. What did the research find about alcohol and other drugs as a risk factors?
A. So, alcohol and other drugs absolutely also play out as a risk factors.

Q. Was that true both males and females across all age groups?
A. That's right.

Q. Can you explain the difference between risk factors and probabilities?
A. Yes. So, well in fact, I would say that risk factors are about probabilities really.

Q. I mean certainties, actually, I misstated the question.
A. That's fine. The thing that sometimes people get a bit confused about is they do think about risk factors as certainties, but obviously they're not certainties. So, having a mental illness acts as a risk factor for suicide, but obviously not all people who have a mental illness die by suicide, and conversely not all people who die by suicide have a mental suicide. So, they're not about certainties they're about probabilities, they're about heightening the risk.

Q. And so, therefore, are prevention strategies aimed at lowering the risk?
A. Yes, absolutely, and across the population, as I said.

Q. Did Ms Clapperton's research find that people both with and without diagnosed mental illness who die by suicide have multiple different immediate stressors in their life?
A. Yes, absolutely.

Q. So, is the combination or accumulation of stressors an important consideration in understanding risk factors?
A. Definitely, and also in understanding the complexity of suicide, I think.

Q. Can I ask you now about suicide prevention initiatives. Does suicide prevention refer to both prevention of deaths by suicide, but also the prevention of suicidal behaviour which includes suicidal thoughts and suicide attempts?
A. Yes, that's right.

Q. Can we return now to what we started discussing a moment ago, and that's the three types of interventions. Can you tell the Commissioners a little bit more about universal interventions?
A. So, as I said, universal interventions target the whole population without identifying those who might be at risk, and the reason they do that is because it's not necessarily always evident who is at risk.

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

Q. Can I stop you there. With universal interventions, do they also concern population level means to improve wellbeing?
A. Absolutely, that's right.

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

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

Q. And, indicated interventions?
A. Indicated interventions do target people who are actively experiencing suicidal thoughts or engaging in suicidal behaviour. So, they for example might include crisis telephone lines, or treatment in mental health services that are specifically designed to ameliorate suicidal thoughts and behaviours.

Q. In your statement you say that it's your firm belief that suicide is preventable: why do you hold that belief?
A. I hold that belief for two reasons: I hold it because, having worked in the suicide prevention field for a long time, both in a research capacity and just in a capacity of talking a lot to people who have been through some sort of suicidal crisis, people who have come through a suicide attempt or a suicidal crisis are often able to say that they're glad that they are still alive and also able to talk about some of the things that were helpful or not so helpful along the way. So, I feel that that's good evidence, that suicide is preventable.

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

Q. You also say that there's still a lot that we do not know about what works and what doesn't work in suicide prevention: why is that?
A. I think one of the reasons that there's still a lot that we don't know is that suicide prevention research is quite hard to do. It's often tricky because, if you're trying to look at whether a particular intervention works, suicidal individuals are often actively excluded from the research. So, we find that the interventions might be helpful but we don't know whether it's helpful for the very people that we want it to be helpful for.

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

suicides.

Q. So, why are suicidal individuals actively excluded from some research?
A. So, quite reasonably, they're excluded because the researchers and others involved in the research craft don't want to do them any harm. So, it's a good thing that people are protected in research, but there's a fine line: it does mean that there are things that we don't know that we would quite like to know.

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

Q. One of the reasons you gave a moment ago for believing that suicide prevention is possible is that, for people who have had suicide attempts and survived talk about what was helpful for them: is that something different from engaging those people in research?
A. Yes, it's a bit of a nuance, but I think people who are actively struggling with suicidal thoughts are more likely to be excluded from intervention research because there's an implication that the intervention might not be the right one for them, or that they might be prevented getting a different intervention that might be the better one. So, they do tend to be excluded from that sort of research, but they're more likely to be included in research that's much more descriptive and which is a good thing. Often, there are attempts to really hear the voices of people with lived experience and hear from them what they think works for them or has worked for them in the past, and also what doesn't work for them.

Q. Can I ask you about global best practice on suicide prevention. Can you tell the Commissioners what the World Health Organisation's position is?
A. So, the World Health Organisation's, I think, recognises that it is tricky and there's still a lot we don't know in suicide prevention. So, they recommend using a suite of different approaches taken from those universal selected and indicated types of interventions. They particularly recommend doing that in a strategic coordinated national way. So, they make recommendations about countries having national strategies for suicide prevention.

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

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

Q. Can I ask you something about LifeSpan which is a particular systems-based approach, we did hear a little about this last Friday when Professor Helen Christensen from Black Dog was here. From your perspective, can you tell the Commission what that involves and how it's being implemented?
A. So, LifeSpan is exactly that, it's a systems-based approach. It involves a number of different interventions, again some universal, some selective, some indicated, and it's being delivered through primary health networks in the various trials that are being run across Australia, so some state-based trials and a national trial.

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

Q. Do you know whether the PHNs actually play a coordination role on the ground, as it were?
A. Yes, I think they do. It probably differs a bit from PHN to PHN, but the PHNs have a role in commissioning services. So, the fact that they're commissioning a variety of services gives them the opportunity to play that coordination role and think about what the best mix of services is.

Q. Can I ask you about the issue of restricting access to means, which is one of the forms of intervention of which you are quite familiar and have done some work; is that correct?
A. Yes, that's right.

Q. What is the evidence in Australia and internationally about how effective this is as an intervention?
A. So, it's one of the few interventions actually for which there is really quite good evidence. So, there is evidence that - particularly when the means of interest is lethal and it's a common means of suicide, restricting access to that means can have a big impact on not only

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

Q. Can you explain the difference between those two things and why it is that restricting access to means can make an impact on the overall suicide rate?
A. Yes. So, for the reasons that I was sort of alluding to, that if you restrict access to a common means of suicide, that accounts for a relatively large proportion of all suicides and you can eliminate that or reduce it, then you can reduce the overall suicide rate.

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

Q. The evidence from studies that have looked at substitution tend to suggest that there is some substitution, either to the same means in a different context, or to other means, but there is an overall net gain. So, although it doesn't solve the problem absolutely, it certainly makes a dent in the suicide rate.
A. I guess the reason - I'm not sure whether I'm pre-empting a question you're about to ask me?

Q. No, you were, but the question I was going to next, so go ahead.
A. The reason people think that restricting access to means is a useful strategy is that it literally does often stop the person in their tracks and gives them the opportunity to think about the choice that they're about to make, which either means that hopefully they will then themselves seek help or alternatively it gives someone else the opportunity to intervene and hopefully guide them to a better course of action.

Q. You mentioned before that effectiveness studies show that this means of interventions is effective when the means is lethal and where it's commonly used. Is there also a consideration about the means being modifiable?
A. Yes, that's right. So, there are obviously some methods of suicide that are less amenable to restricting access to the means than others, but there are some where you can absolutely make a difference if you can restrict access.

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 repotting 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.

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

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

Q. What do you say about the importance of providing assistance to people who are discharged from a clinical service after a suicide attempt?
A. So again, that is regarded as a really good indicated intervention. People who have been discharged from a mental health service after a suicide still are often at quite a heightened level of risk, so good follow-up care is necessary for them; good integrated follow-up care.

Q. Finally, you've mentioned the need to strengthen the evidence base about what works and what doesn't. What are the areas in which more research is and isn't needed, and why is it needed if it is?
A. So personally I feel like, having worked in the suicide prevention research area for a long time, I feel like we've done a pretty good job of all of the background epidemiological research that describes the risk factors; I think we basically know what the risk factors are. But what we've struggled with is doing good intervention research and really working out what works, and equally as importantly what doesn't work in suicide prevention. So, for my money, I'd be putting it into good, solid interventions.

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

Q. What makes you of the view that interventions will contribute to the reduction in suicide?
A. Well, I guess it comes back to what I said earlier about a lot of the risk factors being modifiable. I think if we can develop the ideal suite of interventions that does target people at different points in the trajectory, recognising that, as I said before, the trajectory is

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

Q. Thank you, Professor Pirkis. Is there anything else that I haven't asked you about that you want to raise with the Commissioners?
A. No, I think that's it, thank you.

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

CHAIR: Yes, Professor Fels.

COMMISSIONER FELS: Q. Thank you for your excellent evidence, Professor Pirkis. You just mention in here impulse suicide. Could you perhaps say a little bit more about that?
A. Sure. So, when I was talking about the reason that people think that restricting access to means works, and I said that people are of the view that it stops the person in their tracks and allows either them to choose a different course of action or for someone else to intervene, one of the things that some people say is, it's particularly useful with impulsive suicides, and you can see why that might be so.

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

Q. Just in general, much has been said about suicide, and national strategies and all these kinds of things, but the numbers appear to have been no longer than they have been for a long time. Now, reading your witness statement gives me some idea of what the problems might be, but have you got anything to say about the fact that the number has just not gone down?
A. Yeah. Well, I think it is to do with the fact that we still haven't really quite cracked the nut. We've got better and the evidence base is building, but there's still a lot that we don't know, and I would say that there is

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

CHAIR: Thank you, Professor McSherry.

COMMISSIONER McSHERRY: Q. Professor, thank you very much for your evidence today. You mentioned in your statement that there are global challenges and that at least we have a national strategy and so on, but you've also spoken about the need for international collaborations. I'm just wondering, are there any countries that you know of that are trialling interventions that do seem to be quite positive?
A. Well, I guess there are pockets, but I think that Australia's probably doing just about as well as other countries: everyone is struggling with it. So, the sort of contemporary solution is to try to deliver this suite of interventions, and so there are other countries that are doing that as well, but I don't think anyone else has - no other countries have demonstrably massively reduced their suicide rate and we're going, let's look at them, let's look at what they've done.

COMMISSIONER McSHERRY: Thank you.

CHAIR: Dr Cockram.

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

Can you assist us with trying to understand where some of the epidemiology might be around suicidal ideation and suicide and is there something in there that explains that circumstance to us?
A. I'm not sure, really. I don't know, epidemiology can answer that question. I think it's a very tricky question. The rates of suicidal thinking, suicidal ideation, are much higher than the rates of suicide attempts, and equally the rates of suicide attempts are much higher than the rates of suicide. I think that comes back to it being difficult to

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

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

Q. Is there a risk factor analysis between the ideation and the attempt that is coming into play here?
A. I can't really answer that, I can't speak on behalf of the clinicians who are --

Q. But from an epidemiology point of view there isn't? There's no evidence to say people with this ideation --
A. Well, you could find risk factors for people who are thinking about suicide that might lead them to be the people who then make a suicide attempt, but they're still not going to be sensitive or specific enough to be able to help you go, well, we really need to be particularly careful about that person; there'd just be too many false positives and false negatives.

Q. Just one last point to try and continue to understand this. It would seem from the epidemiology then that this is a group where all should get the selective or indicated intervention.
A. Absolutely, I think so.

Q. There shouldn't be a choice, everyone should get something at that point?
A. I think that's right, yes.

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

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

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

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

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

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

<**THE WITNESS WITHDREW**

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

CHAIR: Thank you.

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

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

(Live stream cut.)

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

<**SUSAN TROTTER, sworn:** **[12.17pm]**

MS BATTEN: Q. Thank you, Susan.
A. Thank you.

Q. Have you, with the assistance of the Royal Commission team, prepared a witness statement for the Commissioners?
A. I have.

Q. I tender that statement. [WIT.0001.0043.0001] Susan, can you start by explaining why you're here to give evidence today, please?
A. I'm here to give evidence today on behalf of my son who took his life by suicide [redacted] on Christmas Day, and also other parents who I actually look after in a support group so that they don't have to go through the pain and the suffering of what becomes the aftermath of suicide.

Q. We would like to hear your story, and can we start, please, when your son was 5 years old; can you tell us what was happening in his life then and what help you sought at that point?
A. When my son was 5 years old, I noticed that he was very disruptive in his class and so did the teachers, so they asked me, requested me to go to a public hospital system and have him assessed. He was assessed with attention deficit syndrome, and back then there was not really any medication or systems that could support you except various appointments and ways of trying to keep him calm and helping him through his schooling.

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

Q. And so, you looked after your son and your other daughter as best as you could?
A. That's right.

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

Q. Can you tell us about that point in his life then, please?
A. Yes. I then asked the school if I could find out if Rowan could be assessed for any problems, and they did an educational assessment on him and they discovered that he had borderline intellectual disabilities. So, for that reason, that's why he wasn't picking up to be able to read and write, because his memory, short-term memory, wasn't available.

Q. And then you've said in your statement that he was bullied a lot as a result of that from school?
A. Yes, he was very badly bullied, even by the teachers as well at the school. He was just too much to handle for them to look after, so I suggested that he should go to a special supported school. They suggested, no, that he was not bad enough to be put into that school and they would support him, but the supports were not there. But he was very smart, he knew how to do his comical little acts to keep everybody away from him to make funny jokes so that they would understand all about him and accept him.

Q. Then you've said, when your son was in Year 9, he just could not cope with school any more?
A. No, he couldn't.

Q. What was going on at that point? You had him assessed?
A. I took him to the GP and the GP suggested - he wrote a letter to take to Centrelink and the Centrelink doctors assessed him, and said that he would not be able to work because of his short-term memory loss and attention deficit syndrome, and also his borderline intellectual disability, so they put him on a disability pension.

Q. And then you've said your son's mental health seemed to deteriorate when he was around 17?
A. Yes, he got very angry, he was frustrated with himself, he felt that he wasn't getting the supports that he needed, and he then took his first attempt of suicide.

Q. After he'd taken his first attempt at suicide, you went to the hospital?
A. That's right, in a public hospital system.

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

A. It was at the Emergency Department, and everybody was trying to make him feel okay, because he had to have his stomach pumped and I had to wait till he woke up from his overdose, and they suggested to me that he needed to see a psychiatrist and have medication. So, they sent me home with a letter and it took two to three months before we were able to see a counsellor or a psychiatrist.

Q. Why did it take two to three months?
A. The waiting list.

Q. After two to three months he got to see a counsellor?
A. Yes, he did.

Q. Did he also have a case manager at that point?
A. He did, he had a case manager. He also was put on medication, antidepressants.

Q. For his mental health journey, did he have the same case manager all the way along?
A. No. No, there was all different case managers because of the workload and the support that was needed.

Q. You said your son was referred to a psychiatrist: did he go and see a psychiatrist?
A. Yes, he did.

Q. What did the psychiatrist say?
A. That's when they said that he had personality disorder and he also needed to be on antidepressants as well.

Q. In between the ages of 19 and 21, you've said that your son was pretty angry --
A. Yes.

Q. -- with himself and he was going through a difficult time.
A. That's true.

Q. What was happening at that point in time?
A. He was very frustrated with himself, he felt that he wasn't normal and he felt that nobody was helping him or supporting him to what he needed. He hated taking the medication, I know that for a fact, so he had several suicide attempts, and it was the same situation: 24-hours, 48 hours at home he'd go after he woke up out of comas.

Q. 24-hours or 48 hours at the hospital and then he was sent home?
A. Yeah, and then he was sent home in my care.

Q. And then, did the CAT Team come and see him?
A. Occasionally, yes: sometimes they would turn up and sometimes they didn't.

Q. You've said each time the hospital released your son they told him to keep up his medication and treatment?
A. Yes, and that was done by a GP, the medication.

Q. When your son was around 21, he was referred to live in a supported living arrangement?
A. Yes.

Q. Could you tell us about the supported living arrangement?
A. It was excellent. They were teaching him living skills, how to be competent, to look after himself. I was involved, which was excellent. They would have parents there and we'd learn, we'd have cooking nights, et cetera, and he was being taught how to look after his money, because with that problem he couldn't look after his money at all. And also, they were there 24-hours and whenever he needed to talk to somebody, or he felt that suicidal attempt come up, he would have somebody there to talk to.

Q. And who's "they" that were there to talk to, were they the counsellors?
A. They were the counsellors and also the support workers who live there, live in basis.

Q. Your son was still fighting his demons during this period, you said?
A. Yeah, all the time, he was always fighting his demons.

Q. Did he have any suicide attempts while he was in the supported accommodation?
A. No, he didn't. He used to feel that he wanted to, or he'd talk about it but they were there for him and I was there for him as well.

Q. And they also ensured that he took his medication?
A. Yes, and that was one thing that was really major.

Q. And so, he was in there for five years, and then he

got married and he moved out of that supported accommodation?
A. That's true, yes.

Q. And so, by this time he's about 26?
A. Yes.

Q. You've said for two or three years your son was in a constant cycle of issues, overdoses and recoveries?
A. Yes.

Q. Can you tell us about this period in your son's life?
A. It was very distressful for me and distressful for him. We were in and out of various hospitals, weeks on end, waiting for him to come out of comas, with no supports. He actually felt sometimes like he was a criminal, that he was doing something wrong. We'd had various family meetings. In one of the meetings I was actually told that my son was an attention seeker and that he would never really take his own life.

Q. You also said that there was a constant rollercoaster of hospital after hospital?
A. Yes, lots of hospitals.

Q. And then, usually when you went to a hospital, how long was your son in the hospital for?
A. 24-hours to 48 hours.

Q. And then, did he have one admission during this time as well?
A. Sorry?

Q. Did he have one hospital admission at one point for two weeks?
A. Yes, he did, for a week to two weeks.

Q. But there was just the one admission generally he was in for 24 or 48 hours?
A. Yeah.

Q. And released back to you?
A. M'hmm.

Q. You've said that you felt like your son was being let down because the hospitals didn't follow through after he was released?

A. Yes, very badly let down.

Q. When he was released to you, what contact did he have from the hospitals?
A. Not very much at all. Nothing at all. He might get a phone call maybe once or twice, but none of that continued, it was just continuously going to the GP or going to the counsellor or his CAT Team or case manager.

Q. Moving to when your son was 28. When he was about 28, your son became a dad?
A. Yeah, and he was the most happiest to be a dad. He loved his son so much, and he said to me, "I promise you, mum, now that I have him I will never try to take my life again because I have something to live for."

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

Q. Can we talk about Christmas [redacted]?
A. Yeah.

Q. You said two days before Christmas [redacted] your son came to your work?
A. Yes.

Q. And he had some court papers with him?
A. That's right.

Q. [redacted]

[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

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

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

And then Christmas morning I got a call from my son to tell me that he had been released - no call from the hospital, [redacted], and then he and his girlfriend went home, were going home, and as they were on the tram - because Rowan was a very strong-willed guy -
- as they were on the tram he said to his girlfriend, "I'm getting off and you stay here" and he jumped off the tram. And then he went down to the railway lines and that's where he sat for a couple of hours.

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

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

had gone somewhere where it was very familiar to him that was very emotional to do what he needed to do, [redacted].

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

Q. Can you tell us a little bit more about the support groups, what are those support groups?
A. After I lost him, I was an absolutely mess. I had been to the Coroners because I had to view him, which was very hard, and they gave me some brochures. I put the brochures away because I didn't think of anything, I didn't want to be here to tell you the truth, I felt so much guilt and hurt inside.

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

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

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

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

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

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

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

Q. Are there some recommendations that you wanted to say to the Commission?
A. I do, yes. I would like to close with a plea to the members of the Royal Commission: please, do all you can to prevent any parent having to deal with the enormous aftermath of losing a child to suicide, having to deal with the hurt, loss, guilt for the rest of our lives.

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

Thank you.

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

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

MS BATTEN: May Susan please be excused?

CHAIR: Yes.

<**THE WITNESS WITHDREW**

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

CHAIR: Yes, thank you.

LUNCHEON ADJOURNMENT

UPON RESUMING AFTER LUNCH

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

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

MS BATTEN: Q. Thank you, Mr Woodward. Have you, with the assistance of the Royal Commission's legal team, prepared a witness statement for the Commission?
A. I have, yes.

Q. I tender that statement. [WIT.0001.0055.0001] Mr Woodward, could you please start by outlining for us your background and experience in the field of suicide prevention?
A. I've worked in the field of suicide prevention and related health and human services for more than 20 years now. In the last 15 years in particular, I have focused on services and programs relating to suicide prevention. I worked for 14 years for Lifeline Australia in various executive roles, including the establishment of the Lifeline Research Foundation.

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

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

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

Q. Could you tell us what are some of your key learnings from working in the field of suicide prevention for 20 years?
A. Yes. It's a field where there are some complications and nuances and many twists and turns in understanding what is really one of the most perplexing of human behaviours: the desire and intent to end one's life.

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

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

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

Q. Thank you. We'll return to some of those themes as we go through your evidence. Just to clarify the parameters, can you explain to us what you mean when you say suicide prevention?
A. I think there are a number of layers to suicide prevention. First and foremost, it is about the prevention of preventable death. And all of us working in the field of suicide prevention are motivated, profoundly, by the desire to prevent needless death and the belief that suicide deaths are preventable.

Q. Why do you hold the belief that suicide deaths are preventable?
A. Well, because suicide is a human experience, it drives a behavioural response, and therefore there are things that can be done to mitigate the factors that might lead to a person's suicidality becoming so intense as their intention to end their life.

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.

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

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

Q. You've referred to "5 per cent of the population", is that any population? Which population are you referring to there?
A. The research is undertaken by Karl Andreas and other researchers as a meta-analysis focuses primarily on western studies but across many nations. So, we might see that study suggests 5 per cent of the population in 12 months and quite plausibly in Australian population.

Q. You've referred to the best way to understand suicide is a person's desire not to live as an expression of profound human suffering. Can you expand on why you think that's the best way to view suicide?
A. Well, it was insight that was gained from the 50s and 60s through some of those who were working in the field. Most notably Ed Shniedman, Bob Lictman and Norm Favaro through psychiatrists operating in Los Angeles who did intensive and very important work in the area of suicide prevention.

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

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

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

Q. Is that not the way suicide prevention is being done at the moment?
A. I think you will find that many of those who are working in suicide prevention absolutely approach suicide from that angle. From my own personal experience as a volunteer on the phones with Lifeline at one stage and through my work with that organisation, I know of the thousands of people who have answered calls or worked in communities and in other organisations motivated by that desire to simply reach out compassionately to help another human in need.

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

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

Q. If this approach is taken, a more compassionate approach, what do you see the implications of that approach being?
A. Well, part of the implication is that it underpins our motivation and our belief that suicide is preventable. Because, once we understand that the experience of feeling profoundly suicidal or a suicidal crisis, is a person's response to what is happening in their life and to how they are, then we don't so much place a blame on the person or seek for oversimplistic solutions to their despair; we start to approach the issue in a more informed and realistic manner, that it's a complicated human behaviour for which a multi-factorial and consistent response is required.

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

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

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

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

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

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

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

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

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

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

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

Q. You've also said:

> "For some people mental health illness is a significant factor in suicidal behaviour."

Can you expand on that, when is mental illness a significant factor?
A. Well, it can indeed be, and there are two ways of looking at this situation: on one hand those with prevalent disorders such as depression and anxiety may be over represented in suicide deaths by more than double. On the other side of the coin, it is estimated that less than 5 per cent of those with mood disorders die by suicide. So, it's an issue, but it's not the only factor.

Q. And so, ultimately you've said:

> "We need to be careful in ascribing a causal relationship between mental illness and suicide."

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

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

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

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

> "From a public health perspective efforts to improve the overall mental health and wellbeing of the population will generate a commensurate reduction in suicidal behaviour."

Can you expand on that, and you gave the example of the European Alliance Against Depression; can you explain what they've done in relation to suicide prevention?
A. Yes, certainly. I guess as a general point, a mentally healthier population will have many benefits, including clearly the participating lives and the enjoyment of life and quality of life of the population, so in that sense it's something to pursue as an end in itself.

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

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

The European Alliance Research is an interesting one

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

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

Q. You mentioned earlier the issue of comorbidity. Why do we need to focus more attention on comorbidity issues?
A. Well, it raises a better understanding of what might be underlying suicidal crisis, but the most practical reason for looking at comorbidity is, it drives what sort of services and strategic responses we need.

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

Q. You've mentioned in your statement that:

> "Providers and professionals in the mental health system need to be skilled to deal with suicidal behaviour and to contribute linkages with other services and support."

Which is again what you mention with the comorbidity. Can you expand on that and how we ensure those providers are skilled in that way?
A. Again, there's a couple of layers there. First and

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

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

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

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

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

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

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

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

First of all, why is that the one key dossier, why are you pointing to that particular document?
A. Yes, I think it's one the key documents because it brings together the collective research and expert knowledge from around the world in the field of suicide prevention in one document. So, I often have said to people, "if there if there's a one thing you're going to read, that's a good one to read".

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

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

Q. What are the key recommendations from that document?
A. The key recommendations are, firstly, that suicide requires a multi-factorial strategic response, and it outlines the case for that and puts forward the architecture for effective national suicide prevention strategies.

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

Q. The Fifth National Mental Health and Suicide Prevention Plan, the Australian document, is based on that WHO model; is that's right?
A. Yes, they've recognised the WHO report. Indeed, Australia is a member nation of the World Health Organisation, so we have both contributed to that report

and we are responsive to that report.

Q. And then also, the Victorian Suicide Prevention Framework is also informed by the WHO report; is that right?
A. It is, in perhaps a less than direct way, in that it has been the case for more than 20 years in Australia but the national suicide prevention frameworks have been mirrored by state and territory governments. So, that generally relates to what are called the national mental health plans and in the last iteration is now the National Mental Health and Suicide Prevention Plan.

Q. At the Victorian level, are there any elements from the WHO report which warrant more attention in Victoria?
A. At the strategic level, no; the Victorian Suicide Prevention Framework does refer to the key elements that are within the WHO framework. Where the issue lies in Victoria in my view is more around its translation into policies and programs and services where there could be shifts in emphasis, yes.

Q. Can you give an example of that of where you see that there's potential for a shift in emphasis?
A. Yes, the one that I would give as an example is in the area of crisis response and aftercare. I should hasten to say that Victoria is not greatly different to other States and Territories in Australia, and that nationally this is an area that we have not invested and undertaken as much efforts in the past as we could have.

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

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

approach to suicide prevention. Can you explain what exists now and what is needed to get that more structured consistent regional approach?
A. Yes. Drawing back to the WHO report for a moment, one of the things that was found there is that there are indeed geographic differences in suicidal behaviour and suicide rates around the world. Within Australia, as a large country with a population spread across a sizeable land mass, there are has notable differences in geographic or regional factors surrounding suicide and suicidal behaviour. Those factors may differ along the lines of the demography of the population, including ages, the economic base of the regions, and social factors including the social capital of regions.

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

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

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

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

Q. That doesn't exist in Victoria at present?
A. It doesn't exist on a comprehensive basis. Victoria presently is showing leadership and responsiveness to the issue of suicide prevention through the so-called HOPE

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

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

Q. So, do we not have that policy funding and evaluation for those trials as far as you're aware?
A. I think that's more a question really for those in government and the relevant agencies to be answering, but I certainly would make the observation that it is an important step to be taking in the future for improved suicide prevention in Victoria to address those two areas which are currently under trial.

Q. In terms of people who are at risk of suicide, are you able to identify any particular cohorts who are at increased risk of suicide?
A. Yes, there are various ways we can identify those who have a greater vulnerability on the basis of statistics. Australia is quite fortunate to have data relating to the profiles of those who die by suicide. Victoria is, in particular, very fortunate to have the Victorian Suicide Register through the Coroners Court system here; there's a very significant database that can provide those insights.

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

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

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

basis, we might want to put effort.

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

Q. Given we have all this knowledge at this point, and the data and the suicide prevention and the Suicide Register, why is it that Victoria has not been able to reduce the suicide rate?
A. Well, I think it is worth making the point at first that Victoria has had a lower than national suicide rate for the last 10 years, and in the last reporting year of 2017 was the only state in Australia that saw a reduction in the numbers of deaths by suicide. So, I would want to put that out firstly just to say, it's not as though nothing's working; there are some things clearly that are working in Victoria around suicide prevention.

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

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

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

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.

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

Q. Still on this issue of measures to work out what's effective, do the measures exist for other programs? So, for crisis response and aftercare, do those measures already exist or do they need to be developed with the appropriate programs being developed?
A. To some extent they exist but more can be done in that regard. So, some programs have established measures that are workable and can be reported against, and for many others there's not. There was an evaluation of the National Suicide Prevention Strategy done several years ago and one of the findings from that evaluation was that, while dozens of projects or services had been supported through the National Suicide Prevention Program, most of the evaluation data was activity based: how many people through the service, how many activities occurring within the service and very little in the way of effectiveness evaluation.

Q. Still on this issue of how suicide prevention should be measured, your view is that the suicide rate is not the single appropriate measure; is that correct?
A. It should not be the only measure. It's one, and it's a useful one, but it's not the only measure. I think that there are a couple of ways of looking at this issue. If I maybe preface my comments by saying, I've worked in evaluation for many years and, one thing that marks better evaluation is where a variety of data sources are drawn on informing the evaluation conclusions. Suicide is such a complicated area of activity to evaluate suicide prevention, we need to look at more than one set of data.

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

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

Q. In relation to the limitations on the data that are currently available, the ABS survey is obviously one example that was conducted a while ago now. Are there other limitations on the data that's available that are hampering effective suicide prevention measures?
A. Yes, there are other areas that we could make improvements, notably through the hospital and health systems. So a proportion of people in suicidal crisis and those who attempt to end their life will become visible to the hospital and health systems, possibly through their presentation at Accident & Emergency because of the injury or their health issue; possibly through other areas of the health system.

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

Q. Are there any impediments to developing a consistent model of trying to obtain that data?
A. Well, it requires a system reform and it requires resources, so in view of other things where you want to collect data and to do it consistently and usefully, it requires people to have the system to do that, to be trained and required to do that and to be accountable for it and for the data to be reported.

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

input into that system reform, or is there still a knowledge gap?
A. There'd be a bit of developmental work to obtain consensus around the coding and the definitions, but I think we have the knowledge that would allow us to do that, yes.

Q. Finally, Mr Woodward, are there any initiatives or ideas that you think could be implemented especially in relation to the concept of distress and human suffering that are not already being implemented in the field of suicide prevention?
A. Well, I think one of the things that is so important is to understand the value of connection and compassion in suicide prevention. So, we can look at, I guess, the more technical aspects and the service responses, including clinical treatments and a whole range of things, but there is a real need for services and community responses to encourage connection between people so that no-one is left feeling alone in their suicidal crisis and to encourage a compassionate response to understand the suicidal crisis as a story of human suffering.

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

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

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

emotional support needs.

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

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

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

Q. Secondly, you just mentioned in passing the data suggests Victoria has a lower rate than other states. Are there possible demographic explanations such as smaller Aboriginal population, maybe fewer people in the farm sector and things like that that could explain why Victoria has better results?
A. Quite possibly all of those things may be contributors to that. Interestingly, the states and territories that have the highest suicide rates in Australia: Northern Territory, yes, has a high indigenous population proportionately; it also has some issues around alcohol abuse and not only in indigenous populations.

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

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

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

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

Q. So, just on that very subjective general statement, you've given us a picture of the complexity of it, the nuances of what's been done and what might be done and so on. I just wonder if a more general conclusion isn't really available anyway, which is that, at the end of the day we've not given it sufficient priority and that's why we have this frustrating failure of the suicide rate to decline, that in the bottom line, is that, had we given it higher priority, we could have had a lower suicide rate?
A. Well, I think, yes, giving more priority is part of it because priority in public policy terms is often reflected in budgets, attention and reporting, all of which are things that I would say are necessary.

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

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

COMMISSIONER FELS: Thank you.

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

A. Very much.

Q. Have you seen examples where that is working, in terms where you genuinely get that commitment to a whole-of-government, multi-agency community response?
A. Well, yes, I think we've done it in other areas in Australia. The example that I would use would be around road safety and the reduction of road accident deaths. Which, you know, I grew up in the 1970s when seatbelt wearing was optional, and the cars went very fast and didn't stop very well and the roads weren't always very good. As a nation we have come together, we've created a National Road Safety Strategy that is then implemented through the various tiers of government, from State Government through to local government. We've got investments in research and technical knowledge on road safety, improvements in car design and road design. We have strategic priority setting around black spot road remediation works, we have community-based education, we're starting from primary school age through, we engage the community in the quest for road safety. We have driver education, we have all these things occur, and low and behold we've reduced the death numbers in the road accident area by more than a half.

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

Q. Thank you. One other issue I just want to touch on in your submission you said, when you were talking about what the trends had been in relation to suicide, there was an increase in suicidal behaviour in young women across the nation, and you referenced an Orygen study that had reported on that. Can you just elaborate further for us about what might that have illustrated, or requiring further attention?
A. Yes, well, the Orygen report is noted where we have had data around presentations on self-harm through the hospital and health systems that there have been an increase in activity through predominantly young women. Now, I don't think we fully understand what that is about

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

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

CHAIR: Thank you. Thank you very much.

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

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

<**THE WITNESS WITHDREW**

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

CHAIR: Yes, thank you.

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

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