COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Suicide in Australia

MONDAY, 1 MARCH 2010

CANBERRA

BY AUTHORITY OF THE SENATE

SENATE COMMUNITY AFFAIRS
REFERENCES COMMITTEE
Monday, 1 March 2010

Members: Senator Siewert *(Chair)*, Senator Moore *(Deputy Chair)*, Senators Adams, Boyce, Carol Brown and Coonan

Participating members: Senators Abetz, Back, Barnett, Bernardi, Bilyk, Birmingham, Mark Bishop, Boswell, Brandis, Bob Brown, Bushby, Cameron, Cash, Colbeck, Jacinta Collins, Cormann, Crossin, Eggleston, Farrell, Feeney, Ferguson, Fielding, Fierravanti-Wells, Fifield, Fisher, Forshaw, Furner, Hanson-Young, Heffernan, Humphries, Hurley, Hutchins, Johnston, Joyce, Kroger, Ludlam, Lundy, Ian Macdonald, McEwen, McGauran, McLucas, Marshall, Mason, Milne, Minchin, Nash, O’Brien, Parry, Payne, Polley, Pratt, Ronaldson, Ryan, Scullion, Sterle, Troeth, Trood, Williams, Wortley and Xenophon

Senators in attendance: Senators Adams, Boyce, Moore and Siewert

Terms of reference for the inquiry:

To inquire into and report on:

The impact of suicide on the Australian community including high risk groups such as Indigenous youth and rural communities, with particular reference to:

a. the personal, social and financial costs of suicide in Australia;

b. the accuracy of suicide reporting in Australia, factors that may impede accurate identification and recording of possible suicides, (and the consequences of any under-reporting on understanding risk factors and providing services to those at risk);

c. the appropriate role and effectiveness of agencies, such as police, emergency departments, law enforcement and general health services in assisting people at risk of suicide;

d. the effectiveness, to date, of public awareness programs and their relative success in providing information, encouraging help-seeking and enhancing public discussion of suicide;

e. the efficacy of suicide prevention training and support for front-line health and community workers providing services to people at risk;

f. the role of targeted programs and services that address the particular circumstances of high-risk groups;

g. the adequacy of the current program of research into suicide and suicide prevention, and the manner in which findings are disseminated to practitioners and incorporated into government policy; and

h. the effectiveness of the National Suicide Prevention Strategy in achieving its aims and objectives, and any barriers to its progress.

WITNESSES

Committee met at 9.00 am

BARBER, Ms Brenda, Suicide Prevention Counsellor, Lifeline Australia

BEATON, Ms Susan Jane, National Adviser, Suicide Prevention, Lifeline Australia

FISHER, Miss Madelin, Suicide Bereavement Support Group Facilitator, Lifeline Australia

O'NEIL, Ms Dawn Marie, Chief Executive Officer, Lifeline Australia

WOODWARD, Mr Alan Roger, General Manager Social Policy, Innovation, Research and Evaluation, Lifeline Australia

CHAIR (Senator Siewert)—This committee is commencing its inquiry into suicide in Australia. This public hearing is likely to be followed by another hearing in Canberra, to be scheduled in the future. Today the committee will be speaking to a number of organisations that have made their own submissions as well as contributing to a joint submission which the committee has also received. We will be in Brisbane tomorrow, Sydney on Wednesday and Melbourne on Thursday. That is the start of the hearing schedule. We are also planning to visit the other capital cities in Australia and some regional centres.

I would like to welcome representatives from Lifeline Australia. We have your very substantial submission; thank you very much. We also acknowledge the massive amount of work you are putting into this issue and the work you have already been doing with the committee. Do any of you have any comments to make on the capacity in which you appear?

Ms Barber—I am a Lifeline telephone counsellor, a suicide prevention counsellor, and a supervisor of counsellors in the counselling room out of hours when they have difficult calls.

Miss Fisher—I am a support group facilitator for persons bereaved by suicide, and I am also bereaved by suicide myself.

CHAIR—As I understand it—and I know some of you would be very familiar with the committee process—you have been given information on parliamentary privilege and the protection of witnesses and evidence. As I said, we have your submission and we have read your submission. I would like to invite any of you or all of you to make an opening statement and then we will ask you some questions.

Ms Barber—Thanks. I am going to make the opening statement, but we do want to leave lots of time for you to ask questions.

CHAIR—That is usually the way that we like it. We get a lot out of the interaction.

Ms O'Neil—As you know, the reason for Lifeline's conception 47 years ago was in response to a suicide. Over the past 47 years we have listened and heard and worked with suicidal persons throughout Australia thousands and thousands of times. As a result of that, we felt and we have learnt that suicide is mostly preventable and there is much, much more that we need to do within the Australian society, within our community, within our medical systems and our support systems, and within community to really adequately respond to suicide. As a result of that we were very keen for this inquiry to take place so that you could consider what the options were going forward. We believe very much that suicide is a whole-of-community issue, that it alone cannot be addressed by one segment of the community—the health portfolio alone or by primary care alone. It must be a response by the whole of community, because suicidal people more often than not will interact and engage with people outside of our traditional health systems—it might be to a Centrelink officer or a financial counsellor. At the moment the stigma of suicide restricts people from seeking help and getting the assistance they need. So there is much more we need to do as a whole of community to really adequately respond.

From our experiences we also know that it is absolutely crucial that there are good pathways to care and that for suicidal people, as much as possible, there is no wrong door that they can easily access help and support, regardless of whether they are a person who has attempted suicide, whether they are acutely suicidal themselves or whether they are bereaved by suicide. We also passionately believe that there needs to be a rethink about the way we manage suicide in Australia, that the governance structures and the way of managing the programs and the strategy and the funding and the research needs to be fundamentally rethought so that it can properly embrace all of those whole-of-community aspects.

I want to introduce my colleagues that are with me today so that you know what questions you might like to ask them. Brenda Barber, as she said, is also bereaved by suicide. She has worked for many years, since 1986, as a Lifeline telephone counsellor volunteer. She also has roles of supervising and supporting telephone counsellors, training them, facilitating small groups and all of those sorts of things. But, most importantly, she has been working in our follow-up service—that is, where people we have identified through our own services as being at risk of suicide, she is able to follow up significantly—and she is going to be able to tell you a little bit more about that. Madelin Fisher, who, as she said, is also bereaved by suicide, runs one of our bereavement support groups, which we also believe is incredibly important. We know from our experience that unless people get good follow-up care quickly after a suicide has occurred in their family or amongst their friends, the risk to them personally of suicide is quite significant. I will let Madelin talk to you more about what she does and how she does it. And Alan Woodward, also from my office, is going to relay some of our experiences of working with emergency departments in particular and those that are responsible for an initial response for someone at risk of suicide. On that note, I will let Alan tell that story first and then Madelin and Brenda can tell you their stories and then give you time to ask questions.

Mr Woodward—I would like to start by communicating the experience of one of our long-serving Lifeline managers:

> The event occurred late on a Saturday afternoon in a suburban accident emergency unit in a public hospital. A man in his 30s was given the cubicle next to my father's.

The Lifeline manager was with there with her father. It continues:

> Two nursing staff made their way over to him. They read out his name and address very loudly. This stuck in my mind as he lived in the street next to my father, possibly they knew each other. The staff continued to talk to the man in very loud voices so that it was easy for everyone in the vicinity to hear, thus the man's confidentiality and privacy were

compromised. The nursing staff asked the man if he had taken an overdose of medication. The man replied that he had. One nurse loudly stated that this was a stupid thing to do. She asked if he had a mental illness. He stated yes. No further question was asked on this. The man volunteered that he suffers from depression and had for a long time. The nurse asked if he had children and the man stated that he had. The nurse loudly stated that it was a terrible father who tried to kill himself and leave them. He stated that they would be better off without him. A nurse stated that she would be the judge of that and that he was wrong and this was a stupid action. The nursing staff asked if he had a partner. He said that she had left him a long time ago. The nursing staff asked why he had tried to kill himself. He said that he was angry, lonely and depressed and did not know what to do. They asked him why he got angry. He said he did not know, but he felt angry a lot of the time. Then they left him.

What is happening here? A man still feeling suicidal has found something—enough—to keep him from ending his life and has taken a specific step to live. Rather than being encouraged and given support for this action, he is berated in a public space, with others overhearing the conversation. He must have felt humiliated. But what if this man had experienced a coronary arrest? Possibly he would have received sympathy and dignity despite the medical emergency. Possibly he would have been given some privacy and reassurance from the nursing staff while waiting for the treatment. His family would have been notified and, when they arrived, taken aside and have had the medical condition explained to them, as well as offered personal support and advice on how to keep their loved one safe. Why is it that a suicidal person is not treated in a way that at least allows them dignity and the usual rights of any person to fair and professional treatment? Why is it that our system of medical response does not include mandatory procedures to facilitate referrals to other support services when a person is suicidal, in the knowledge that these individuals are at high risk of attempting suicide again? Why is it that our response as individuals and as a society to suicidal persons so lacks compassion?

Lifeline believes that whatever else is provided to suicidal persons, whatever else is done to keep suicidal persons safe, whatever else is done to prevent the onset of suicidality, there must be genuine, non-judgmental caring in our response. To do otherwise is to profoundly miss the point about suicide—that suicide is a human experience originating in the depths of despair and misery—and the starting point to respond effectively to one person’s suicidality is to meet them in that low point and start to explore messages for hope and a possibility of change even in the most difficult of times.

The renowned academic and writer Thomas Joiner, who is regarded as one of the founding fathers of suicidology, recognised this human dimension in his discourse about the perceived loss of belonging and the loss of hope experienced by suicidal persons. In many respects the way in which suicide safety, treatments for suicidality and suicide prevention is conducted raises profound perspectives on human rights in a civil society. As a society we may be measured on how we treat our most vulnerable members. Lifeline urges the Senate inquiry to consider in all its deliberations the importance of creating a human response to suicide in Australia at all levels and in all communities.

Ms Barber—This is a situation I dealt with quite a few years ago but it has stayed with me. I was asked to support a young person who had phoned the crisis line and was very suicidal. When I made the first call to her she had the equipment with her, ready to end her life. All I managed to do in that first encounter was to get her to put that equipment away out of her reach and agree not to use it. I said I would ring her the next day. I rang her every day for about two weeks. She had been seen by the medical profession—by a GP and a psychiatrist—she had been hospitalised and she had been on drugs for her condition. But she felt that that was impacting upon the career that she had just started and it would go against her, so she was reluctant to return to the medical profession, and the future for her seemed very black.

I found that there were some things that gave her a bit of relief and helped her complete the day and go to work. I gained her trust, and she would tell me about her situation at work and the people that she felt would support her and help her deal with the people who were being rather hard on her. I talked to her about what kind of medical help she thought she could find agreeable and helpful, and she said that she would like to see female practitioners. She then thought that in the area where she was living there was a female GP that she felt that she could trust, so I thought that she could go and see that GP and get a referral to see a psychiatrist, because I felt that she needed medical help and a lot of support. I also knew of a very good young psychiatrist that I felt would be a good person for her to see. I do not know if she actually went to see her, but over time she was seeing a GP every week and a psychiatrist who she got on well with. She felt that she could trust them and she would be able to continue in her chosen profession.

I was talking to her for six to eight weeks, and we would get to just calling her two or three times a week. From hardly saying a thing in the first few days, she went to volunteering to tell me things about her life, and she had started to talk about her future. We got to the point where she said, ‘I think I’ll be all right now.’ There were people in her family that she realised could help. She could rely on her sister. Even though she was living at home with her parents, she felt that it would be a burden for her parents to talk to them a lot about how she was feeling. So she went from, in my visualisation, holding on by her fingertips to life to seeing that she had a future.

Ms O’Neil—That story illustrates how people at risk might take that brave step to call us, and we are in a position to be able to assist them to work through their own issues and hold on to living until they can get further care. Often it takes a long time. It is not a one-off visit, and I am sure you know this. A suicidal crisis can last a long time, so people need really quite intensive support and care. They are able to do that, often, while maintaining their daily living—going to their jobs and those sorts of things. They are working through all of the issues until they get further help. I might let Madelin tell her story now; it is more focused on those that have lost someone to suicide.

Miss Fisher—My first encounter with suicide was in 2004. I was working in a Mexican restaurant an hour and a half away from my family home, and my mother appeared at the door of the Mexican restaurant where I was working and she came in. I remember thinking, ‘What are you doing here?’ She came and she had tears in her eyes, and she said to me, ‘We’ve found your uncle’s body.’ My uncle was 49, and he had taken his own life very suddenly and unexpectedly. I saw the trauma that it caused my family—my grandmother in particular—and I remember thinking: ‘God, I hope this never happens again. It can’t happen that often.’

Unfortunately that was, I suppose, a preparation for what was to come. On Anzac Day in 2007, my boyfriend at the time went out drinking and he did not come home. I remember that I was driving around in the rain that night looking for him, because he was not where he was supposed to be. I was calling his phone and it did not answer, so the next day I reported him missing to the police.

It was at 2 pm that afternoon that two police officers came round to my house under the pretence of taking a statement for a missing persons file. They sat down at the kitchen table with me and they said, ‘We’re sorry, but we found his body.’ He was 23. I looked at one of the police officers, who I think was just as baffled as I was, and I said: ‘What do I do now? Who do I talk to?’ He looked at me with pity in his eyes and he just said: ‘I dunno. Maybe go and see your GP.’

That was just the beginning of my journey to acquire the help that I needed, a journey that was confusing, difficult and not easily facilitated at any point or in any place. I quit uni, naturally; I could not cope. I went to Centrelink after they cut me off and they told me I needed to get a job. One GP that I went to told me I was being a silly girl and that he was not a very good man for me if he had done that to me. He told me I was young, I was beautiful and of course I would find someone else. Naturally I was not particularly impressed.

It was not until sought face-to-face counselling from Lifeline that I had anyone to help me address the feelings of loss, abandonment and guilt, feelings that seem to be universal in people that have lost somebody to suicide. That is how I came to facilitate a support group for people bereaved by suicide. In the beginning it was a purely selfish motivation. All I wanted was to connect with another human being that was going through the same thing or had been through the same thing and someone else to say, ‘You can live through this.’ Everywhere I went I saw no proof of anybody that could possibly deal with so much pain.

I finished my uni degree. I am now embarking on another and I am starting medicine. I feel incredibly grateful that I was given the support from Lifeline and the support for my family to do that, but I know from my work with the support group that not everybody has access to resources and to people to support them, to love them and to tell them: ‘You can live through this. This is going to be a scar on your heart for the rest of your life, but you can do it.’

Grief as a result of suicide is different to other grief. It requires another level of meaning making to get through the grieving process. Bereaved people are also more likely to attempt or complete suicide, as all our research shows, because of isolation, the lack of resources, their impaired judgment and feeling like they do not belong. It makes people incredibly vulnerable. Many people do not survive. There was one woman in our group who had lost three sons. The first had suicided and she was unable to prevent the second son and then finally the third from following. I cannot imagine a greater tragedy than knowing that you have lost one son and then not having the resources to be able to protect the remaining two. I just cannot imagine anything more heartbreaking.

This is horrifying but, knowing what we know and reading the submission that Lifeline has made along with the other, innumerable submissions that have been made to this inquiry, it is not surprising. I hope that you can take on board a little bit of my position, as someone who has been bereaved by suicide. We are an incredibly large community. They estimate that, for every one person that dies by suicide, a minimum—and I think this is a very conservative estimate—of six other people are directly negatively impacted. That is an incredible number of people that are in a lot of pain and do not have the resources to help them cope. Thank you for considering this.

CHAIR—Thank you.

Senator MOORE—Ms O’Neil, we have very limited time, as you know. We will probably be talking to you again in this process. You have put an extraordinarily large number of recommendations in your submission. A lot of them are grouped together in terms of focus. Could you tell us the major expectations you have? You can read it and you can read all the others that have lots of recommendations, but it would be useful if we could get from you and your organisation exactly where you think we should go.

Ms O’Neil—No. 1, there does need to be a fundamental rethink about how we coordinate and organise suicide prevention in Australia. To be very honest, having it largely operating out of health departments and government agencies is not the most effective way to coordinate a community-wide approach to suicide prevention. That is fundamental.

We need absolutely more accurate data, and that will require an independent collection source that is not reliant on the burden of proof that coroners need currently, so that we can get access to timely data. We know that clusters of suicides occur within small communities. The community itself may be somewhat aware, but service providers are not finding that out until years later. It is just too late. But there are ways, and I know that you will hear from people who have thought through how that can actually happen. We need better access to data so that we can respond more effectively.

Fundamentally, we need a significant increase in resources and funding to do suicide prevention. The comparison between what is spent in suicide prevention in Australia, which you know is around $30-odd million a year specifically on suicide prevention, compared to what we spend on road trauma and other causes of death, is such that it is nowhere near going to reach all of the people that it needs to reach to ensure that there are bereavement groups everywhere, that we follow up compassionately on every single person who comes to an organisation who is at risk of suicide and that no-one is excluded from the service system because they are suicidal. To be able to do that effectively is going to require significantly more resources.

On awareness and stigma reduction, there does need to be a significant program, like there has been for depression, to reduce the stigma associated with suicide so that people will access help, those barriers are removed as much as possible and the whole community is equipped to be able to respond, so that they do not feel afraid, scared, terrified—all of the things that happen to people when you start to talk about suicide.

Senator MOORE—Thank you. We are going to have a lot of information about data—

Ms O’Neil—You will.

Senator MOORE—because it is a thing that has attracted attention. I think there has been attention on suicide for a while. Whether it has had the focus that it should have had is another discussion, but the data stuff seems to have been really pressing buttons recently. The subcommittee that was formed to look at data collection was through the strategy but it was also coordinated through—

Ms O’Neil—Suicide Prevention Australia.

Senator MOORE—SPA, and they have got this process. Was your group involved in that?

Ms O’Neil—Yes, Susan was involved in that committee.

Ms Beaton—There were a number of organisations involved in that, and there was a separate submission made from that committee for the work that has been done to date and the projected work that is planned. I think everybody who has an interest in that has been involved with that. It has been very collaborative across organisations.

Senator MOORE—And it is ongoing?

Ms Beaton—Yes, it is.

Senator MOORE—One thing I have not been able to get my head around is this: it reports to government?

Ms Beaton—That is correct.

Senator MOORE—And is there an end date for that? That may be not a question for you. It seems that that subgroup has joined the concern that the data process we have is not really giving an accurate reflection and, as every program and media coverage quotes figures, if your bottom line data is wrong, you are operating from the wrong premise. I will follow up on that, and I am sure other senators will, but for the sake of time I will pass on. We could go all day.

Ms O’Neil—Just on that.

Senator MOORE—We should, but—

Senator ADAMS—Where to start? I come from a small rural community. I am just thinking back on some of the suicides that have happened there and the way the community reacts, because there really has not been any medical help apart from a solo GP and the nursing staff at the hospital, of course. Communities tend to not want to interfere with the family. That is always the hardest thing, and I think, being involved in the community for a long time, you do sort of sit back and think, ‘Should I or shouldn’t I?’ But I am a nurse, so I am probably a little bit more prepared to move out of that comfort zone and go and talk to the family.

The hardest part for a number of people, those that are left, is that they blame themselves for the fact that they should have recognised the problem. So often, the people that do attempt suicide or else unfortunately succeed are very—I do not know whether the word is ‘clever’—good. They may have decided to do this a long time ago, and usually, when you work backwards through it, you find that there was a trigger probably a year ago or 18 months ago and they have slowly worked their way up to think about how they can actually take their life. I think this is where the families feel that they missed that trigger and if they had only picked up on it perhaps that person still would be with them.

Firstly, I know it is the bereavement side with the support group, but these little communities do not have that sort of thing, unfortunately. The other thing is that you may get someone who means well but they put their foot in it all the way and end up causing probably more problems. One other issue is Indigenous deaths as well. That is an even harder one to deal with. Could you just give us a little information on that?

Ms O’Neil—Sure. I am happy to start. I think there are many things that we can do. It is our experience—and Brenda and Madelin are here to testify—that volunteers, ordinary lay people, ordinary Australians, can be trained and can learn how to respond in that empathic, compassionate way and provide the level of support that is needed. It does not have to be paid professionals. I think that if we are going to rely on paid professionals to resolve this problem we will never arrive. We must use the resources that are in the community.

CHAIR—Ms O’Neil, I am sorry to interrupt, but this is along the lines of a question I wanted to ask. It follows up from what Mr Woodward was saying. I take your point about volunteers, but it was quite obvious in the situation that Mr Woodward described that the professionals at the time responded inappropriately, and it seems to me that they need training about how to deal with that particular situation as well.

Ms O’Neil—Yes.

CHAIR—No matter how good your volunteers are, if you are getting that response at the first point of contact, that is an even bigger hill that the volunteers then need to deal with.

Ms O’Neil—Yes, you have picked up a very good point there, and it is not to ignore the professionals. Obviously, they also need training. We know that for most GPs in their medical training, perhaps less so for nurses but even for psychologists, the actual training on suicide prevention, risk assessment and response is very, very minimal. So we do need to absolutely up the ante on training for professionals and allied health professionals and at the same time train the community so that, in small communities where there may be only one GP, there is a network of people within that community who are equipped and prepared and know how to respond. We believe very much that it is much like the ABC of heart response, where we are all trained to know what to do when someone has a heart attack in the room. We know the basic intervention at first. We need to train the whole community in the same way, so we need suicide prevention first aid officers in every workplace, in every community.

Miss Fisher—Yes, and I think it is important to recognise that Lifeline does deliver the ASIST program, which is suicide first aid. That is something that I was talking about. I am interested in trying to lobby—I am doing medical schools—to introduce the two days of ASIST training to medical or health professionals that are up and coming so that, even if we cannot get through to every health professional who is working now, our next generation of people who are coming out, the new graduates, are going to start off with a fresh, good set of guidelines of how to respond to the people that they are going to come in contact with more and more frequently.

Senator MOORE—So that would be the core curriculum rather than something you choose to do.

Miss Fisher—That is exactly right.

Senator MOORE—Senator Adams, I know that is your area too.

Senator ADAMS—I have got lots of questions but I would like to perhaps move on to the Indigenous issues and how you cope with that. Once again in Western Australia we have had some very tragic follow-on suicides in the communities. Ms Barber, how would you deal with that if someone rang and said, ‘Look, we are desperate. The town is desperate’?

Ms Barber—If somebody rang saying that there had been a suicide.

Senator ADAMS—A number of suicides and the town was looking for a way to try and get everybody together to cope with it.

Ms Barber—It is not really easy over the phone, but the people who were concerned could have the Lifeline crisis line so that they could have somebody at the end of the phone they could talk to. But if they could contact their local Lifeline centre maybe the people in the area could to the assist training course. It is like a first aid certificate in a way, that every few years it is really a good idea to do a refresher, a one-day course like the first aid certificate, so more people are aware of help that is available for suicide people, something that has been talked about rather than kept secret.

Ms O’Neil—I might just add that I was privileged to be able to attend the Billard blank page summit on suicide in July last year. It was a very strong message from the small communities like Balgo that have been deeply affected by many suicides that that is what they want: they want training, they want everyone in the community to know what to do and what the signs are and what can be done. They want training and support. They will never have enough staff to be able to respond but they want to work out a community wide strategy within their community and they want everyone to be trained and they want the support to be able to support each other and help themselves.

Ms Beaton—I am sure the senators are aware that Indigenous suicide is different and it is a relatively recent phenomenon. It really needs to be dealt with in a way that acknowledges that, so it is integrated within the whole approach but it is different and it needs to be specialised. I am sure you are aware of that.

Senator ADAMS—Once again this is difficult in a community that is mainly Indigenous, they have got their family groups, but you find within a bigger community, an agricultural town for instance, people really do not know how to bridge the gap to be able to reach those people and do not want to be seen to be interfering. This is probably the key to smaller communities. In the city it is a very different thing, but in a community where everyone knows everyone, how do you take that first step?

Ms O’Neil—I think engaging with the community, much like the Billard summit. Those communities were asking for support, they were expressing a personal and a community wide need for someone to come in and provide them with training and support. That was the thing that came up over and over again: we want training; we want to do what we can do. Then they will work out a strategy for within their community. There are always leaders within those communities and they are very concerned about losing so many of their young people. So I think we need a team of people that can go in and provide that level of support, to assist them, train them, so that they can then be able to be self-determining within their own community and have a community wide strategy, safe houses, safe places to go and everyone in the community knows who the go-to person is if someone is at risk and that they are equipped to be able to support them.

Miss Fisher—I think it is important to point out that what we are aiming for is a whole society change in the way that this problem is viewed, in trying to break down those preconceived notions that by going and saying to someone, ‘Listen, mate, how are you today?’ you are not being nosy. This is a human experience and it is human to become involved. In the small communities you get the impression that it is viewed as being nosy—‘I’m being nosy, this is none of my business, he is not doing too well, he has been acting funny, but who am I?’ It is important to look at this as a change which we want to resonate throughout society, to make it okay to say, ‘How are you?’ and to be able to comprehend and understand the answer and, hopefully, it being an honest answer.

Senator ADAMS—How much do you have to do with local governments as an organisation?

Ms O’Neil—Because we are located in 60 communities, our local centres engage with their local governments quite considerably.

Senator ADAMS—But overall Lifeline as an organisation does not have a link to local government? I am asking to try to get a mechanism somewhere which perhaps may be the key to it because local government is representatives of the community.

Miss Fisher—It is interesting. I am from Newcastle and in Maitland they have just set up a suicide prevention network. The local government has identified that there is an extremely high rate of suicide. As a result, Lifeline has partnered with a couple of other organisations. Basically, once a month, all parties with a vested interest in suicide in the area get together—it includes ambulance services, various non-government organisations and healthcare providers. This is loosely based on the model used in Norway. Norwegians were obviously pioneers in suicide prevention. The preliminary results of what they have been doing with the suicide prevention network in Maitland have been very encouraging, for the organisations to create links between each other and with the local council, to identify what needs to be done, to raise any issues, to communicate current clusters, suicides, concerns with delivery of services and that is fantastic. Things going well and with more research, depending on how effective this is going to be as a service, it is something which could be set up and run in various communities throughout Australia and hopefully have success.

Senator ADAMS—That is good, thank you.

Mr Woodward—Could I had a couple of comments around the role of local government—it clearly could be more. One of the aspects of effective community-based suicide prevention involves elements of leadership and local government is often very well-placed to harness leadership in a community. So the equipping of people involved in local government or the equipping of the local councils to bring forward leaders into a network that positively promotes suicide safety and suicide prevention is a very clear role. A second role is that local government can do things on the ground. Depending on the actual circumstance, size and context of the local government, conceivably there are community services provided and also linkages with state and federal. Recommendation 27 in our submission was to see that all levels of government—federal, state and local—commensurate with their role, fund and support those who are involved in suicide prevention. There is perhaps more potential for local governments, state governments and federal to work collaboratively across program and funding boundaries.

The third area I would suggest is that local government can often play an important role in facilitating community action. In many states and territories in Australia local governments have a social planning role and it would be very beneficial if suicide prevention was factored into every local government social plan, so that the community response was thought about and planned for. Likewise, local government can facilitate knowledge and expertise coming in and communities desperately need that resource advice sometimes and sometimes practical assistance around issues of suicide prevention. In the United States there is a national suicide prevention resource centre set up and resourced which includes elements of, I guess, a consultancy role to communities who want to do suicide prevention work. It does not impose, it does not come in over the top of communities, but it does provide expert resources, expert personnel and also a best practice register which showcases and makes accessible to all people that which is known to work well.

Senator ADAMS—I wonder why is it recommendation 27. It should be a lot higher.

Senator BOYCE—I am not sure who to direct his question to but I would like to start by saying thank you very much for your submission. Like everyone else, I could ask questions pretty much all day. It is not all that long ago that not only was attempting suicide a crime but it was a sin. Lifeline comes out of the Uniting Church. Could you tell me a bit about your knowledge of the attitudes of faith based communities to attempting suicide?

Ms O'Neil—I do not know that I am the right person to speak on behalf of the church but certainly from our engagement with the Uniting Church I know that long ago they withdrew from condemning a person or a family for a suicide occurring. I do not know exactly which year, do you?

Mr Woodward—No.

Ms O'Neil—For the other churches I am not so sure but my understanding is that most of them have abandoned the belief that suicide is a mortal sin and that therefore you cannot be buried with everybody else in the cemetery.

Senator BOYCE—It obviously feeds into stigmatisation to a very large degree.

Ms O'Neil—Absolutely and I think we still live with that stigma and taboo around suicide because of both the legal framework that was in place not that long ago—20 or 30 years ago—and also the church.

Senator BOYCE—To play devil's advocate, if we were to normalise suicide, would we run the risk that it would become an acceptable thing to do?

Ms O'Neil—That is a fantastic question which has been debated long and hard. The clear evidence now is that talking about suicide does not put people at risk of suicide, as long as the discussion and the conversation is done in a sensitive and careful way, that we are not sensationalising suicide, we are not glorifying it, we are not glamorised in it, because there is certainly nothing glamorous about it, but that it is spoken about in terms of how we keep people safe, that the impact of suicide is incredibly negative on family and friends and that every life is worth living and as a society we must do everything we can to help a person hold on to living and to find reasons to live.

Mr Woodward—The emphasis needs to be on normalising human experience, including misery, and normalising help-seeking and creating a community that promotes help-seeking.

Senator BOYCE—That is a good distinction to make. Thank you, Mr Woodward.

Ms Beaton—I think our society does not generally deal well with death because we do not talk about it. It is happening a bit more now but if we do not talk about it then we will not be hurt. Those things need to be talked about sensibly and daringly.

Miss Fisher—That also goes back to the reluctance of media to address the issue and for us to address the issue of suicide in a public forum but, as Dawn said, all our evidence now shows that using the mind frame guidelines for reporting on suicide there is no indication that by reporting on suicide or discussing it in the media do we encourage it in any way and there is no significant evidence to indicate that people are going to be more likely to attempt or complete suicide because it has been discussed in the media if it is done under those guidelines.

Senator BOYCE—This includes celebrity suicide, because there seems to be some suggestion that that is different and can cause imitative attempts?

Miss Fisher—Generally—we brought Kurt Cobain up earlier on. Maybe you can share that.

Ms Beaton—It is an issue which I am sure it will have a conversation about across the next four days and forward. The mind frame guidelines are very clear about how to and how not to. I guess we are moving forward with a notion of—

Senator BOYCE—How to report and how not to report.

Ms Beaton—Exactly. You are right. If there is a celebrity suicide and it is poorly reported, there certainly is research evidence to show that there can be an increase for people who are vulnerable. Regardless of the circumstances, those guidelines need to be adhered to. Those of us in the industry are looking at how we can discuss it healthfully and helpfully and encourage those conversations at every level, including in schools. Children will talk about this. It is part of their lives. How can we encourage those conversations that are healthful for them and that help to sow the seed, as Alan said, that there is always help available? We do need some structures and guidelines. Very well-meaning people say things that are inappropriate. There is risk, and we do need to be cognisant of that. But I think silence breeds stigma and stigma breeds silence, and we have to break through that and be able to talk about suicide in a way that encourages people to understand it better, to seek help and to become more informed. Most people only know about suicide when there is a policeman knocking at their door.

Senator BOYCE—Ms O’Neil, your first recommendation is that Lifeline become a type of 000 number for suicide. This could be seen as empire building. Could you just explain to us a little bit more about why you think a non-government organisation should be doing this and not a body like 000, for instance?

Ms O'Neil—Firstly, Lifeline's brand, its name, is already very well known. We have 96 per cent brand awareness across Australia and in some places it is 100 per cent. So we are already trusted and known. We have the ability to provide compassionate care, and there are no time limits on our phone calls. We know that supporting a person to stay alive often takes a long time. There is, I guess, a whole structure which makes sure that our service is accessible. Part of the reason for putting forward the 000 number as our first recommendation is that, at the moment, we are not in fact an essential service. However, many of the people who call us do so from a mobile phone and they are being charged for that call. Our real intention is not just to build our empire but also to make access free and timely for callers. The main purpose behind the 000 is to make sure that everyone has access, that it does not cost them anything and that there are no barriers to their seeking help.

CHAIR—Unfortunately, we have run out of time, which I knew we would do because (a) your submission is so comprehensive and (b) there are so many issues that we need to cover. If anything else arises as a result of our questioning that you would like to comment on please feel free to let us know and send us a letter. We may also have some questions on notice—I have a couple that I did not get to put to you today—so we may be in contact with you again. Thank you very much. Your evidence and the effort you have put in are very much appreciated.

Ms O'Neil—Thank you.

[9.54 am]

CROSBIE, Mr David, Chief Executive Officer, Mental Health Council of Australia

IRVING, Ms Rachelle, Director, Projects and Research, Mental Health Council of Australia

TATZ, Mr Simon, Director, Communications, Mental Health Council of Australia

CHAIR—Welcome. I understand that you were given information on parliamentary privilege and the protection of witnesses and evidence.

Mr Crosbie—Yes.

CHAIR—We have your submission. I would like to invite any or all of you to make an opening statement and then we will ask you some questions.

Mr Crosbie—Thank you. I want to start by acknowledging the committee's interest in this area. As members of the committee you have shown a longstanding interest and, in many ways, are becoming experts in your own right on some of the issues. I think it is to the good of policy making in this country that we have people who are committed, interested and engaged in this way. We appreciate that interest. I think the whole mental health sector appreciates that interest.

I want to very briefly explain that the Mental Health Council of Australia is a national peak body. Our membership includes almost all the major national bodies in mental health as well as the state peak bodies, consumer and carer groups, researchers and professional bodies. This submission has been through all of them, so it is very much capturing the views of a very wide group of people who are all engaged in mental health, and many of them very directly in suicide.

This issue for us is obviously very critical. It is a very important issue for the Australian community. Suicide has a massive impact across our nation, and it is important that we begin to address it more effectively. Too many of us have been touched by suicide in various ways. Too many people have experienced not only the loss of a loved one but the very real sense of the loss potential that this represents for our communities and our country.

Our submission is in some ways picking up on many of the other submissions that you have received. I think there are many common threads throughout all those submissions. Our emphasis is perhaps a little more on the mental health system and responses. Like others, we are concerned about data and accountability. We also talk about the need for increased investment. Those two issues in particular are very strong themes in the submissions that I have read. Further, we talk about the need to target at risk communities.

I do not intend to speak for any length of time. Rachelle, who is with me, has extensive experience in reviewing the needs of at risk groups, including Indigenous communities. Simon is with me because of his extensive experience in working around communication and the media issues associated with the image, the social construct, of suicide in our community. We reiterate what is in our submission and would like to use the rest of this time to engage in a discussion.

CHAIR—Thank you. Ms Irving, Mr Tatz, do either of you want to add anything?

Ms Irving—No.

Mr Tatz—No.

CHAIR—Then we will go straight to questions.

Senator MOORE—Good morning, everyone. It is nice to see you back. I have two questions. One is in terms of the mental health plan that has just been endorsed. From your understanding of it, because I know that you are deeply involved, are the issues of suicide effectively covered in the plan?

Mr Crosbie—In Australia, we have a tremendous tradition of writing wonderful plans—

Senator MOORE—And guidelines.

Mr Crosbie—and guidelines and policy documents. Our concern is the way in which they are implemented and the degree to which they actually reach the community and make a real difference. We have no major concern with the *Fourth national mental health plan*. It is a very good document. It does talk about suicide, perhaps not as extensively as we would like. Our concern is the degree to which that can influence national practice. At the risk of talking too much about the mental health system, I have to say that we think the way in which people currently respond to crises in other people's lives is woefully inadequate.

Mental health crises almost invariably end up with police, paramedics or hospital emergency departments, and our response at those points is woefully inadequate. In 2006, 77,000 presentations were made at emergency departments in New South Wales alone for people who said they had chronic mental health issues that needed urgent attention. Less than one-third of those were admitted. Most went away without any follow-up or any real treatment and yet these were people in crises. Some were brought in by police, some were brought in by paramedics, some were brought in by carers. The way we respond to people who are experiencing difficulties is at the heart of how people enter our mental health system. When I look at the *Fourth national mental health plan* I do not see that it will drive the kind of reform that is needed in those areas.

Senator MOORE—You are certainly not alone. Ms Irving, we do not have a lot of time, but I would like to get something on the record from you, particularly about how you think we should move forward and any comments you could make about the Western Australian summit that was held last year that focused on the issues of suicide in Indigenous communities.

Ms Irving—First of all, I would just like to acknowledge the specific interest that the Senate is showing to Indigenous suicide instead of lumping it in with the whole-of-population problem. I have a couple of things. I think it is important upfront to note that we all know about the problem of intergenerational trauma within Indigenous populations. In looking at Indigenous suicide you really need to view it in context of that intergenerational trauma. You need to look at the perpetual cycles that are happening in communities—substance abuse, sexual abuse and ongoing physical abuse. If you do not look at it with that holistic view then it is difficult to look at suicide as an isolated incident. There are many good programs. When I was doing the research to put the submission together the thing that became clear to me was that there is a lot of grey literature out there about programs that are working in Indigenous communities. But most of them are not peer reviewed. Only a few have evidence based findings. I think it is important to highlight that in order for us to work out solutions for Indigenous communities. We need to go to those communities and we need to talk to them.

You mentioned the Billard summit. That was a good way of highlighting work that has been done in those communities. That was not of course evidence based. Basically, if we go into those communities and ask them what is going on, they know what the problems are and, generally, they also know how to fix them. The thing that came out of Billard was that they do not need people coming in and telling them what to do. They know what the problems are; they know how to solve them. They identified themselves that the women have become very strong in the communities and, as a consequence of that, the men have become disempowered. They then tend to drink more and become more physically abusive. So they are losing their ability to become leaders in the community. Certainly, that is not to say that what they found in that particular community is exactly the same as what is going on in every community. But it highlights the importance of going into each one of them to find out what their problem is. We may find that it is consistent across the board, but it may not be. I put into our submission the importance of holding something like a series of workshops, to go into communities, in a strategic way, and to speak to a large number of communities to find out exactly what their problems are, hearing it from them and hearing what they think their solutions are and then moving forward from there.

Senator MOORE—Using a model, whereby you get people together and give them time and support—I want to get the issue of workshops on the record, because it was a really positive suggestion—using the kind of experience, the summit that was held, so we have seen something that happened. We are not creating something new but using that model extensively.

Ms Irving—That is right—that bottom-up approach, so starting at the community rather than deciding at a government level what needs to happen and then going in and telling the community. There is enough evidence to show that that has not necessarily worked. The thing that came out of Billard was that community members there were working really well with people who had various degrees of experience. High-level government people were also there, but everyone was working together on the ground to find out what the problem was. That was a really good example of what needs to be done.

Certainly, you would be aware that a lot has happened since Billard, which was in August last year. The O’Reeri family and the Victor family, which held the summit, have progressed a lot since then. Last week I spoke to Kari Kristiansen, who is one of the cofounders of that summit, and she indicated that another one is going to happen again this year. So they are planning on making this an annual event. I guess that brings me to another point: it is about finding out what is working in communities, not just them keeping that information to themselves but then disseminating that information throughout the country and sharing that knowledge so that other communities can learn from that.

Senator MOORE—It is not a one-off step, either?

Ms Irving—No.

CHAIR—In fact, the experience with all Aboriginal communities is a lack of pilot programs, a lack of resources, a lack of follow-up. Programs work for a little while. They go in and do a workshop. Is it worse not to do it in the first place and not follow it up and get people's expectations up and then not put in the resources? Is there evidence to suggest that if we are going to be rolling out these programs that we will then be backing it up with the resources and then not coming in using the top-down approach—in other words, believing what the community says?

Ms Irving—You have hit on something there. It is about trusting the community in that they can fix the problems and understanding that the way they fix them may not be the way that is used in traditional non-Indigenous communities. Using a program where you provide them with funding for 12 months or two years will not work because it will take an Indigenous community—I am generalising here—a lot longer to work out how they are going to do things and they may not follow the same systematic steps that a non-Indigenous community may follow. So we need to understand that and, for want of a better word, we need to trust them that that will work.

Mr Crosbie—If I can just add that I think that innovation and pilot project fatigue is a really fundamental question. The Australian mental health sector is littered with project epitaphs, saying, 'Here lies the "we did good program".' It does not just apply in Indigenous communities. Our failure to adopt and adapt programs that we have seen that have a significant benefit should be an indictment on all of us. We go off and develop new strategies, new plans, new policy documents but we do not build on what I often see are very good innovative local solutions that are working. Even the ones that are well documented are not picked up and supported nationally. This is one of the major issues. So many people in Australia are doing excellent work in their local communities: reducing isolation, creating connections, building support services for people, but they flounder on inconsistent funding, inconsistent support, inconsistent adoption and adaption of what they can see is working. Rather than writing new strategies and new plans, I think we would be much better trying to implement, adapt and adopt some of what we have already seen works.

CHAIR—Can I follow up, which leads to this issue around the grey literature, Ms Irving, that you were talking about. There is a lot of thinking, particularly in Aboriginal communities, around these other programs. They are not necessarily peer reviewed. I am not for a moment underselling the fact that we need excellent research but, in some communities, we do not have time for a 'dot the i's, cross the t's' type approach and my experience with particularly Aboriginal communities is that there is a lot of grey literature and it is not believed, it is not followed up. You have to dot the i's and cross the t's. I wonder whether there is a process in place. Could we put a process in place where we can review the grey literature to a point where people are happy with it, but we do not have to dot the i's and cross the t's before we sign the cheque?

Ms Irving—I guess that was where my concept of the workshops was first born. There is going to be an aspect where you sit down and have a group of people plough through the information on the internet. But I think a lot of that will be missing what is actually happening, which shows the importance of going out to a number of communities and, in a systematic way, over a few months, actually asking the questions as to what is happening in the community. As you would know, there are not a lot of computers in these communities. We do not even have a clue about a lot of the information at the moment.

Mr Crosbie—I notice that we have just relaxed the laws around clinical trials to get drugs that show good promise to the market, which I must say is a wonderful innovation. It always interests me that we can do this in some areas but not in others. We also have programs that are very well documented, like Act-Belong-Commit in Western Australia, where there have been pilot communities and control communities. We have shown that in the pilot communities it has reduced isolation, reduced hospital admissions, reduced drug use, reduced crime. These are relatively inexpensive programs. I do not know whether it is because it is from Western Australia or because it has been trialled in rural communities or because there is evidence. I do not know why it is that you would not just say, ‘Here is a program that actually makes a difference to the way people feel about their community.’ It is not a magic bullet that is going to solve everything, but it is certainly a massive step forward. Why do we not adopt and adapt? Each jurisdiction feels the need to develop its own version of engagement and Act-Belong-Commit. I really struggle with what it means for people in our community that we have to go on letting these programs lapse and then reinventing them.

CHAIR—I have another question, which is a complete jump from where we were before, and that is about support after release from hospitals. It has been a big issue in a number of places. In my home state of Western Australia I know of a number of cases where people have not received support and they have ended up having a successful attempt or where very last-minute intervention has fortunately prevented another attempt. So I would like to get a bit of feedback on that, if possible. It seems to me from reading the submissions that it is a major issue and it is where a number of successful attempts are made. What are the key things we do there?

Mr Crosbie—Again, I think this is a very good and important issue to have upfront in any report about suicide. Our current systems do not provide follow-up. I do not know that they ever can in the way they are currently structured. Hospital staff, and particularly those who work in relation to mental health presentations, are under incredible pressure. They are rationing services. There is a very high demand for, and a low supply of, the kinds of support that people need. We have very limited community backup. There are not a whole range of community mental health programs out there that you can refer people to or connect people to. We know that the referral completion rate—the number of people who actually follow through on a referral from an emergency department—is very low. I think we have a major systemic problem when hospitals are the go-to places for people who are suicidal or are experiencing other mental health crises. We need to create alternative options. Lifeline have just presented information to you. Certainly telephone counselling provides one service and the internet provides another, but we need physical locations in communities, away from hospitals. We expect emergency departments to cater for any kind of family crisis, from aged care to paediatrics to mental health, and somehow ration services in a highly stressed and difficult environment and then appropriately follow up. Most people presenting are not going to be admitted when they have a mental health problem. So the system, as it is currently structured, has some really basic, fundamental structural flaws in terms of responding to people’s needs.

Senator BOYCE—I will just follow up on that. One of the statistics from Lifeline’s submission was that only 30 per cent of people who have attempted suicide end up in an accident and emergency department. Where, from your experience, do the rest go? Where are they?

Mr Crosbie—I am probably not the person who can tell you but I am not sure that anybody really can. That is the indictment, I think, of where we are. It is my belief that there are many suicide attempts that we do not see, we do not record and we do not intervene in. I am not sure of the exact number; I know there are estimates, but I think there is still very much a stigma, a barrier, to people acknowledging that they are experiencing mental health issues or feeling suicidal, which means that people can go through a process of making a decision to suicide, attempting suicide, recovering from that suicide and people around them do not know. I know of instances where, later on, that has been divulged. It is really frightening that people can go through that whole process and there is no point of intervention, no service or acceptance that that is needed.

In this context I note that when the Canadians decided that they needed to do an anti-stigma campaign and they were looking at where best to target it, they reviewed what was happening to people and they reviewed people’s experiences and, on the basis of that, they said, ‘We need to start with the health system.’ With respect to the stigma around experiencing a mental health problem and gaining appropriate treatment, as the story that Alan Woodward told earlier demonstrated, our health service system is not necessarily the place you would rush people to if they were experiencing a mental health crisis, because it is not responsive to their needs.

Senator BOYCE—Mr Crosbie, I think you have probably addressed some parts of this already, but in your submission you talk about seeing ‘precious resources going to antiquated systems and failed programs.’ Could you perhaps talk a little bit more about what you are specifically thinking of there?

Mr Crosbie—I think the resource allocation at the moment tends to be, in a sense, after it is needed. The investment we have the most of is around acute service systems. For me it is very much like, ‘we keep investing in ambulances at the bottom of the cliff and doing very little to put the guardrails on up top to stop people coming off. I am not trying to be critical of acute care or to suggest that we reduce their resourcing. But the bottom line is: if you are responsible for the ambulances, and the bodies are piling up down the bottom of the cliff, it is not unusual that you would ask for more ambulances. I think that any of us who have sat in an emergency department and watched the rationing of resources, the rationing of care, will be saying, ‘This isn’t right.’ The intuitive response is that we need is more doctors, more beds. People should not have to experience this pain. People should not have to wait this long. We need to do something about that. We need to fix it. We need to put in more hospital beds and we need to have more doctors.

Our concern is that because the focus has been on trying to fix the acute end, we simply have not invested at a community level in the kinds of services and go-to places we need; nor have we invested in the prevention end. For as long as we do not, we will continue to have far too few acute beds. Even if we added another 1,000 acute beds today, they would be filled within a month, we would still be turning people away—

Senator BOYCE—That long!

Mr Crosbie—I heard about a situation recently where it took only two weeks to fill a new 15-bed facility. We know that many of the people in those beds, up to 40 per cent, would not be there if there were community based options available. We know that around one in seven people who get into those acute beds will be back within 28 days, so we are creating a revolving door for many. I do not know of any other health condition where we consider that an adequate performance. For as long as we keep desperately trying to get more ambulances to the bottom of the cliff to pick up the bodies, I think we will be missing the opportunities and, more importantly, we will continue with a dysfunctional system that does not respond to people's needs.

Senator BOYCE—One last question: is suicide always a mental health issue?

Mr Crosbie—No, I do not think suicide is always a mental health issue. I think this gets back to the issue of the degree to which we create a social construct around experiencing discomfort, mental anguish, pain and unhappiness and the degree to which people can see trials and tribulations as a part of life experience.

Senator BOYCE—The happiness myth.

Mr Crosbie—I do think that to be truly happy you have to experience true sadness, and that dichotomy does not seem to have got through. I do not want to sound like an old man lamenting things, but in some ways there are people who rely on making us feel unhappy until we buy whatever product it is that is going to make us feel better about ourselves, about our appearance, about our house or about our family. I sometimes watch television, I see the advertisements and I wonder what they are advertising because of what they portray. You can watch a bank ad or a fast-food ad and you do not actually see the fast-food product until the end, because what you see are families getting together and playing sport or children realising their potential and you do not know what the ad is for, and then you see it is for a bank or whatever.

For me, I think we have created a social construct around what a psychiatrist who worked for me one day a week for eight years at Odyssey House described as hedonism gone wrong. He described it as failed hedonism—the sense that we wanted things immediately and if we did not get them we were unhappy, and if we were unhappy there was something wrong with us. So I think there is a social construct.

I also think, though, that to look at suicide and try and simply prevent suicide as an activity is probably going to miss many people who are experiencing all kinds of mental health problems, some of which lead to suicide, some of which lead to depression and some of which lead to drug use. We need to think about reducing levels of isolation, increasing connectedness between people and having the support services there for when those broader systems of engagement, support and connectivity are not working very well. I think isolation is the enemy of good mental health; connectivity is also the enemy of suicide. We should be trying to decrease isolation, or people's perception of their own isolation, and increase connectivity more broadly. In that way, we will be targeting suicide but we will also be targeting other things.

Senator ADAMS—I would like to turn to the role that the internet plays in suicide, looking at Facebook and perhaps some of the comments about those two children who were killed recently—not that it was suicide. You talk about isolation. Often young people find the computer is there and that is their friend. They are safe there because they can be unidentified in what they do and what they ask. It really does concern me with this issue as to whether you have copycats or somehow not good ideas. How does the Mental Health Council use the internet to put its message across?

Mr Tatz—That is a very good question. There are a couple of things with that. One, of course, goes back to the issue of stigma and campaigns. We know that where there is a vacuum, where there is no strong discussion and leadership—and we do not have a national anti-stigma campaign in mental health or in any of those sorts of areas—what happens is that young people will use their own ways of communicating: Twitter, Facebook. They have their own email and other contact and it is very much part of that rejection of adult or mainstream attitudes. So it is very difficult to control or know how to deal with this, but one of the things that I see is that, if we do not have strong national campaigns and strong leadership to direct the debate about suicide and to direct the way we discuss or show leadership in this, those kinds of things will flourish in a way that we cannot necessarily control.

I am a very strong advocate for the types of campaigns we have seen with skin cancer, with breast cancer, with drink driving and with a whole range of health and social issues. Yet there is nothing in mental health. Where there is a vacuum, where there is no information or discussion by experts to remove the taboo and some of the stigma around that, what I believe happens is that there is a flourishing of types of media that we have a lot of difficulty controlling. That is often the social networking and the media young people use.

Mr Crosbie—I think it is important to say that I am one of those people who see these things as a wonderful opportunity. I think people can be connected through the internet to other people and it can help and can make a difference. Some of the work that is being done at the Australian National University and some of the work that is being done on various websites and online help services is very positive. I also see some of the behaviour around Facebook and online social networking to really be a reflection of the broader community’s social behaviour. I do not know that there is any evidence that there is a specific kind of behaviour or a specific kind of relationship created between people that is completely different from the kinds of relationships that we see mirrored in the broader community.

If we want to change relationships on Facebook I think we have to think about how we change relationships between people fundamentally. It is a tool. It is another way of talking; it is another way of engaging. I struggle with it, I have to say. I am not a regular Facebook user. I am not someone who occupies the social networking sites. We can look at the negatives of those sites and the negative consequences but we also need to look at the positives and try to accentuate them. I think there has been—it gets back to an earlier discussion—some very good work done in this area that shows great promise that is yet to be fully supported or adapted or adopted in Australia.

Senator ADAMS—I have another question on the national suicide bereavement strategy, which the department completed in 2006. I will be asking the department this but I thought I would ask you first seeing you had it as one of your recommendations. Could you give me any reason why that particular strategy has not been released?

Senator MOORE—Or have you been given any reason, Mr Crosbie?

Mr Crosbie—No, I have not been given any reason why that strategy has not been released.

Senator ADAMS—You have been following it up though obviously to see what is going on or when it may—

Mr Crosbie—I think it is one of a number of areas where we need a much higher investment and to be rolling out what we know has been shown to be effective. It has echoes for me of the need to do what you have very clearly identified is an area where we are not doing very well at the moment. I do not think we are doing very well in that area, just as we are not doing very well in following people up, just as we are not doing very well in discharge from a whole range of settings—hospitals, prisons, alcohol and drug services, mental health services—just as there are a whole range of service gaps that we have been talking about. As Simon said, it requires some level of leadership and investment that I do not think we have seen in this area.

CHAIR—I want to go back to this issue of data. Again, I did not get a chance to ask Lifeline about this. You are recommending an independent, transparent process. Can you outline what you would see as an independent data collection process?

Mr Crosbie—I think the tendency is to collect a lot of activity data. Our mental health sector is very well documented in terms of activity. There are annual reports about the level to which people with mental health problems present at emergency departments and about the number of beds and those kinds of issues. There is very little data about what happens to people. There is very little data about people’s experience of care. There is very little data about what happens when people seek care. As you well know, service systems tend to be blind to the people they do not see. Many of our service systems do not see people who are experiencing mental health problems or experiencing suicidality. Because of that, we do not collect data on them.

If you want to collect data on people’s experiences, then you have to collect data on people who are outside the traditional mental health service system as well as people who are inside, and you have to collect data that extends beyond the point of contact with those services. We have nothing that does that at the moment aside from our decade-apart national household survey. For me, the investment in actually knowing what is happening to people at a community level requires that it be outside of the service system, simply because most of the people experiencing mental health problems and most of the people experiencing suicidality are going to be outside the existing service systems.

CHAIR—I am wondering who does it and how you collect it. How do you get to those people that are outside the current systems?

Mr Crosbie—It is actually not that difficult. Some senators will be aware that I spent quite a lot of time in the alcohol and drugs sector. We have a National Drug and Alcohol Research Centre that has 120 staff. We have a National Drug Research Institute in Western Australia that has 40 staff. We have a National Centre for Education and Training on Addiction in South Australia. They are all invested in by the Commonwealth at significant levels. When I look for similar things in the mental health sector, looking at what is happening in terms of good practice, in terms of people’s experience, in terms of documenting trends, we have a dearth, a real lack, of any evaluative research about how effective programs are. We have a real lack of a bringing together of the researchers who are trying to do work in this area and creating the kinds of economies of scale and the kind of capacity that is needed to actually say what is happening in mental health in this country at the moment. We do not know. All we know is that most people are outside the system.

In the alcohol and drug sector, they do a household survey every three years of 25,000 households. In the mental health sector, every 10 years we do 7,000 or 8,000 households. I just do not understand why you would not. There is documentation about data that is indicative of issues from allied data sources—ambulance call-outs, police call-outs. This is well documented in the alcohol and drug sector. They can say how many ambulance or police call-outs there are for heroin overdoses. If I ask for that data on mental health, I cannot get it. For me, it seems as though we operate in very much an outcome-blind system. The investment that is needed is relatively minuscule compared to even just the amount we spend through the Medicare Benefits Schedule on providing services to people through GPs and psychologists. If you took just two per cent of that expenditure and put it into better data collection, we would make a massive step forward in knowing about people's experience of mental health and mental health services in this country.

Senator MOORE—We are talking with Griffith tomorrow, which has been funded in the suicide research area. It will be interesting to see what they say their remit is, because, by the titles, it could be anything. Some of the concern with data collection is that the definitions are difficult. When you have a call-out for drug or alcohol issues, it is really simple—it is drug or alcohol. But that could well be mental health. It could well be domestic violence. It could well be something else. With D&A, some of the stuff is to do with the definitional aspect. You also get the privacy aspects, which come in everywhere. So this committee is going to focus a lot on data.

Mr Crosbie—I think you understand this issue very well, but let us take a simple thing like, say, I wanted to measure the levels to which men wore yellow ties in this country—

Senator MOORE—And why.

Mr Crosbie—I do not even have to ask why. If I wanted to do that, think of the definitional issues we would have—they would be massive. What is yellow? To what degree is a tie yellow? Is it yellow or some other fawny colour? What is wearing? If I put it on to go to a meeting and take it off the minute I get to my car, have I worn it? What constitutes a tie? Is a cravat that is below a certain length a tie? We could spend hours. I am sure people could write PhDs on definitional issues about how you measure yellow ties.

CHAIR—They may well have!

Mr Crosbie—For me, you would say, 'We're going to count the number of yellow ties in stock in this group of menswear shops today and we going to count them again in six months time and again six months after that,' but it is not perfect. It is not going to tell you exactly how many men are wearing yellow-coloured ties. But if you do not put those measures in place—if you do not go for some proxy measures—you are always going to have definitional issues. Researchers love definitional issues and I think we lose the plot. You were talking about how simple it is to know whether it is an alcohol and drug problem—it is not, I can tell you!

Senator MOORE—It is relatively simple for data collection.

Mr Crosbie—I remember the coroners trying to work out what a heroin death was. In the United States, if I am on methadone and I walk into some place, pull a gun and shoot someone because he has had an affair with my wife or something, it is called a heroin related death because I am on a methadone treatment program for heroin. The definitional issues are always going to be there. It is the stuff that researchers and others can really have a great time with—and I am glad they do—but can't we just get some proxy measures now, establish some benchmarks around those measures and then regularly go back and see if we are doing better or worse. If we wait for the definitional issues to be resolved, we will still be discussing what yellow is in five years and we will not have any measures at all in place.

CHAIR—We have run out of time, of course. Your evidence is very much appreciated and we thank you for your time.

Mr Crosbie—Thank you for your interest.

Proceedings suspended from 10.37 am to 10.53 am

DUDLEY, Dr Michael, Chairperson, Suicide Prevention Australia

McGLAUGHLIN, Mr Ryan, Chief Executive Officer, Suicide Prevention Australia

MAXWELL, Ms Sara, Development Coordinator, Research and Policy, Suicide Prevention Australia

RILEY, Ms Joanne, Board Member, Suicide Prevention Australia

CHAIR—Welcome. I understand you have all been given information on parliamentary privilege and the protections of witnesses and evidence. We have your submission, which we have read. I now invite you—one of you or each of you, whatever you have decided—to make an opening statement and then we will ask you questions. I know you are fairly familiar with the process.

Dr Dudley—Thank you, Senator Siewert. I will lead, but my colleagues will also contribute to and amplify some of my introductory remarks. Thank you for this opportunity. We acknowledge the Ngunnawal Indigenous owners of the land and we also note not only their hospitality but also the significance of suicide for Aboriginal people in Australia.

This inquiry is, as I think everyone appreciates, very timely and is not, I believe, intended to have a defensive intent or a critical intent in the sense of adverse intent. Regarding government or the Department of Health and Ageing specifically, there have been challenges and obstacles in the past and there has been a lot of movement of staff, and some of the processes around granting—for instance, competitive tendering—have been challenging for small organisations outside the university sector. There has been more stability lately and a more collaborative style across government and also across the sector. I also acknowledge our colleagues who are here today presenting before you with whom we have been working closely. We also note that a number of these organisations are represented in the suicide prevention task force. So there has been a greater degree of continuity in recent times.

There has been some concern in some quarters about the upcoming release of ABS statistics—and I will return to those later. There is some concern that this may be seen or as a win or an opportunity. We are here to improve the whole-of-government and whole-of-community response to suicide. We acknowledge good achievements from NSPS, the National Suicide Prevention Strategy—not yet fully evaluated—but we note that it is not truly a national strategy per se, which is one of our central points.

Suicide officially accounted for 1,881 Australian deaths in 2007, but underreporting makes it 2,500—conservatively, a more likely figure. Suicide leads causes of death in young men and also men in late life and records show, and underestimate, 85 admissions per day nationally for self harm, in which women are disproportionately represented. Suicide and self harm are stigmatised. They enormously impact family, friends and professionals. Suicide is a human rights issue. It is that because those suicide attempt survivors and those bereaved are not treated, in our view, as fully human in some ways. In community services, policy making et cetera they are not fully, and that is a major omission. This is a matter that ought to concern governments not only in relation to instrumentalities that concern government, such as the armed forces, the military and the commission of people to psychiatric hospitals, but also in relation to the whole-of-community approach.

Certain groups are proportionally overrepresented in suicide—for example, small rural and remote. Indigenous suicide rates are particularly high. It also affects refugees and those in immigration detention. And we could list a number of other groups that are affected by high suicide rates. It significantly exceeds the road toll—we conservatively estimate its cost at $17.5 billion per year—yet it receives, comparatively, a tiny fraction of funding compared to the road toll. We believe that suicide needs to be comprehensively costed in Australia and that resources need to be allocated to do this.

This year will prove pivotal. The inquiry, of course, has attracted intense interest. Leading mental health advocate Professor Pat McGorry was named as Australian of the Year. He has been outspoken on this issue, as you will know. The ABS statistics are being reviewed. A national committee has been convened to look at standardised reporting. This year, 2010, will see a major international suicide prevention conference in Brisbane in November, which our organisation is co-hosting. This will set our local problems and efforts to change things in an international perspective. This inquiry will also be on the menu at that meeting. So this is also a really important opportunity.

As an organisation, an independent peak advocate body, we have four submissions before the inquiry, and we have in recent years majored in position statements. These are foundation documents that inform the community about central matters to do with suicide and suicide prevention. We have also raised the data issue and convened a national committee about this. We have a suicide prevention task force. We also have suicide prevention days and forums and a governance reform process, though we still have a proportionately tiny establishment.

Suicide is a mental health and social problem. This leads to the need for universal programs and targeted programs. We are united with the mental health sector in emphasising the need for genuine reform in that sector, early intervention, intervention throughout life and getting mental health and suicide prevention out of emergency settings and into the community. We also need social approaches and evaluated community development strategies with respect to this problem, and we have been instrumental in producing some of those. We have been involved in a community life program, a DVD to help rural men, launched by the WA Department of Agriculture, Super Friend and other examples.

It is our belief that we need a complete overhaul of approached to suicide prevention in Australia. My colleagues are going to speak to those in greater depth. We need better coordination, reflected in a truly national suicide prevention strategy. We need a massive increase in sustainable recurrent funding for services, research, infrastructure, monitoring for suicide prevention and for mental health. We need a new governance sector—and we will speak to that. We need a number of strategically aligned organisations to take this forward if we are going to succeed—a national coordination body, a peak advocacy body, a national suicide prevention council and resource centre and a national foundation. We need to secure proper approaches to reporting suicide. We also need advocacy and de-stigmatisation.

We need to have a responsible public discussion, led by the national advice—fully consulted—and, where possible, driven by suicide bereaved and suicide attempt survivors. This needs to be consistent with existing guidelines. We need the participation and support of those bereaved and affected by suicide attempts and their carers in treatment, policy making, services and public discussion. We also need to tackle the notion that suicide is not preventable. We note that 20 or 25 per cent of people in the community believe that suicide is not preventable. We think that that is a major impediment to progress. That is quoting a Lifeline Newspoll survey from late last year.

We need to adopt interventions known to work elsewhere, internationally, like community safe houses. They are sanctuaries for suicidal people. We know that they work in the UK and other places. They have never been adopted here, but they should be explored and resourced to work. There are also postcards that save lives of those surviving suicide attempts or other high-risk populations; and innovation with new, evaluated strategies for high-risk groups that have not been mentioned. I mentioned rural, remote and Indigenous but there are also gay, lesbian, bisexual, transgender et cetera.

Our organisation is better positioned than ever before. The task, in a way, is in its infancy. We have good collaboration across the sector. But if suicide is truly to be tackled, we need radical support from all quarters, including government, to realise the blueprint that we have proposed. I will leave it at that. I did allude to the statistics and I am happy to elaborate on those and the costs if you require me to. They may come out in my colleagues' discussion or we can return to those.

Ms Riley—I would like to thank the committee for the invitation to be here today. It is a core principal at SPA that we include in our work the voices of those who are impacted by suicide. For this reason it was really important to us to make sure that we did invite the public to put forward their stories to help inform our submission to the inquiry. I do hope that, despite the font size, you have been able to get through those stories and absorb them, because there is a lot of valuable information in there. I would also like to take the opportunity to acknowledge all those people who did contribute to the submission in that way.

I had the privilege of personally managing the process of collecting and compiling the stories, and to be honest it was a much, much bigger job than I had ever anticipated, as the stories just kept rolling in. We received stories from people who had attempted suicide, experienced suicidal thoughts, been bereaved by suicide or felt impacted in some other way. So big was the task that I did not have the time or energy to write my own story to include it there. My dad, Tony Riley, died on 31 May 2005 at the age of 60. I only had time to include the photo of Dad, No. 88. It was important for me to have him in there, but to be honest, in going through all of the stories, I felt less anxiety about not having the time to get it in there because there was so much commonality in the stories and I felt that others, through expressing their stories and their experiences in their words, had in part shared my story too. I felt such a strong connection to what many people wrote.

I would say that the fear that I felt when I saw the terror in my father's eyes as he was overcome by hopelessness and depression, and the confusion and helplessness at not knowing what I or my family could do to get Dad support or even to get support for ourselves, was common. Also common were anger and frustration: frustration at a health system that did not include his loved ones in his care plan—we were his support network, and he fell through the gaps because we really did not know what to do or understand the risks—and anger towards others for ill-informed comments about Dad's suicide that really only added to the trauma of losing him. Also in the stories was the crippling sense of grief that made it so difficult to concentrate, to work, to study or even at times to be around people; the emotional pain of watching loved ones going through their own grieving process; and the way that Dad's suicide brought some of us closer together but also ripped some of us apart. They were such far-reaching personal costs, and there were so many feelings and experiences that I shared in common with the writers. Of course, all of their stories are unique, and there is diverse experience, but there are some themes in there.

In the months after Dad died, I made a personal commitment to take some action. I thought that, if I could just stop one person from taking their own life by drawing on my own experiences, while it would never bring Dad back it would in some way honour his life. I saw this sentiment in so many of those stories, and so many people expressed this desire to speak about their own journey. Of the 50 people who directly answered the question that we posed about whether they thought that it was important to have their voice heard, 45 answered a very clear 'yes'. Many pointed to the therapeutic value of being heard, while others expressed a desire for the lessons learned from their experiences to inform our health system and potentially help save another's life.

But, while so many expressed the need to be heard, the experience of about three-quarters of the writers was that people are not prepared to talk about suicide. Their comments frequently mention stigma, embarrassment, fear and judgment. There was a sense that suicide is being kept in the shadows and is a source of shame. Many, especially those that have attempted suicide, believe that suicide is misunderstood and that their desperate desire to end not their life but rather the emotional pain they were feeling is not recognised.

This silence around suicide inhibits our ability to teach people what to do when faced with a suicidal crisis, including where and how to seek effective help. As such, this silence contributes to our suffering and to the death of over 2,000 Australians every year. To break this silence, we believe that we need to create not only an awareness of suicide but also a safe environment to talk openly and debate the issues. To achieve this, SPA believes that we require public awareness campaigns that encourage help seeking and build hope and resilience. We also need suicide-specific education and tools for our communities. This public awareness needs to extend to issues which contribute to suicide as well—things like bullying, discrimination and alcohol abuse. Further, the voice of those with direct experience of suicide needs to inform these activities, as they are the ones who will know best whether we get it right or we miss the mark.

While it was encouraging that so many of the people who wrote their stories were aware of mental health campaigns like beyondblue, many also pointed out that, when it comes to suicide, we need to address much more than mental health. There is a need to build on the progress made to date in that area, but we also need to acknowledge the complex array of social factors that contribute to suicide. It is this complexity that leads us to advocate both universal and targeted campaigns and programs to ensure that the knowledge and tools for prevention, intervention and postvention reach all segments of our community.

It is important to acknowledge that some of those in our community who are the most vulnerable to suicide are also difficult to reach via universal programs or have specific needs—groups such as young men, Indigenous Australians, rural and remote communities and GLBT communities, and also those who have previously attempted suicide. For example, we know that young rural men are the least likely to respond to universal campaigns and they need a targeted response. We need to get through to everyone so that all members of our community feel that they are included and that they are valued. We need to get the message out there to our community that suicide is preventable. SPA endeavours to do this with all our activities, especially the community forum we hold on World Suicide Prevention Day in September every year and also our position statements on key issues. Even more so, we need to ensure that we equip people, especially our young people, with the skills, knowledge and social connections to help protect them against suicide in the first place. The personal stories we receive, however, not to mention the rate of suicide we know exists in our community, quite clearly indicate that so far we have not done enough as an organisation or more broadly as a community and that we require significant expansion in this area.

Mr McGlaughlin—Thank you very much for the invitation to speak today. It is a privilege. I also thank Jo for sharing her personal story with us. I think that what Michael and Jo said is that we do need more government investment in suicide prevention infrastructure, but we also need to get smarter about inter- and intraservice coordination, including research, community awareness and education, funding and service provision functions, and ensuring minimum duplication and gaps in bridging our pathways to care. Although suicide and self-harm are extremely complex phenomena for which there is no single cause or one solution, we need to strive for a much better coordinated and multistrategy approach to the issue. HIV-AIDS is a complex issue, but our response in Australia has been one of coordination and partnership—a good example. I must say that I came from the HIV-AIDS sector and one of the first things I noticed when I got into this sector was how uncoordinated we were across Australia. I stress that this is a very major thing that we need to get much better at.

The responsibility should not just lie with health but with a whole-of-government approach and a whole-of-community approach. There is a need and an opportunity to provide greater community ownership and engagement. We urge the Senate committee to strongly consider the SPA established Suicide Prevention Taskforce submission ‘Let’s get serious: the infrastructure to effectively address suicide in Australia’. The importance of this submission is that a new model needs to be found and that the status quo is no longer good enough. Therefore, we recommend the submission to the Senate.

We need a separate coordinating body and a new governance structure, potentially independent of government and service agencies. This new structure needs to be able to bridge gaps between health aspects of suicide prevention and social aspects. The new structure needs to be able to tell the personal stories and utilise them in healing and in suicide prevention. There will be a greater opportunity for diversity of funding with greater community ownership. We need a whole-of-community and a whole-of-government approach. Suicide touches the lives of our whole society and therefore it is everyone’s business.

Ms Maxwell—I would like to just quickly sum up some of our key points. We need to get the data right. We need mortality data, but also suicide attempt and self-harm statistics. We refer you to the NCSRS submission for evidence and more information. We need to explore the feasibility of and promote universal and targeted public awareness campaigns that safely bring suicide out of the shadows and allow for productive dialogue that harnesses community energy for action. We refer the Senate committee to the Suicide Prevention Taskforce submission, ‘Let’s get serious’, which marks the possible pathways to developing effective suicide prevention infrastructure which will improve governance, coordination and value for money. We need to do better in terms of providing widespread, accessible and sustainable mental health care. Unless mental health services of every discipline are available for people in need in their own communities, other suicide prevention efforts may be ineffective.

Senator MOORE—It is almost an insult to get into the few questions we will have time to ask in response to such an extensive submission. I did tell you that I was going to ask questions about data, though, and I know that the subgroup that you have is working particularly on the vexed issue of data. It permeates so many of the submissions. Maybe this would be a chance for you to talk about how we get better data, why it is wrong and what we should be doing about it.

Senator BOYCE—Senator Moore, could I ask a related question?

Senator MOORE—Sure.

Senator BOYCE—All our statistics tell us that the suicide rate has dropped. Do you agree with that?

Dr Dudley—Thank you for the question. Perhaps I can answer the second question first. The indications would seem to be—and I cite an article which is in press of Andrew Page and Richard Taylor at this point—that the suicide rate since 1997, which was the peak year in Australian suicide statistics, appears to have fallen. That is notwithstanding the comments that have been made by us and other bodies in recent times about the question of data accuracy. So there has been a fall, but it may be more moderate than we had actually thought.

The data, particularly the inaccuracy of the data, is an issue that has arisen particularly since 2002. It is a complex story; it is not a conspiracy. It is a story about a technical problem with cut-off times for reporting by the ABS. The ABS has always had a strict annual reporting cycle which cuts off in March, or whenever it is. The problem has been that there has been an increasing delay in the finalisation of coronial verdicts such that coroners have not been making the deadline. Therefore, ABS has been coding those deaths as accidental and the ruling up to fairly recently was that ABS did not return to actually recode those deaths, so that contributed to increasing rates of accidental verdicts. That has actually been changed now.

The second thing that made a big difference to the accuracy of data was the inception of the National Coroners Information System and an increasing reliance on electronic means of data capture. With the transfer to a purely electronic system, there had been an abandonment of file inspections at coroners’ offices. So ABS coders were no longer going to offices and doing file reviews. That meant that the accuracy was also in more jeopardy. We are talking about a timing delay. But those things have contributed to issues to do with accuracy, particularly in the years 2002 through 2006.

Senator MOORE—Why particularly then? Some of the other submissions have talked about a worsening data situation, which piqued my interest. Why particularly in that time frame was there a problem?

Dr Dudley—We do not exactly know what the internal processes have been within the Australian Bureau of Statistics. We can only rely on their reports and their technical notes. They have qualified these results for some years; it is not like they have failed to reveal that there is some doubt around these figures. Internationally this is a major problem. It involves not just suicide data but all mortality data. Australia does pretty well internationally in terms of coding. We are at the world's leading edge in terms of trying to get this right. Nevertheless, there is this difficulty.

ABS has particularly had—although I do not quite know what the story is—problems with a shortfall in resources for it to do its work. It is massively underfunded in terms of coders who can actually look at these doubtful cases. There has been a reduction of significant staff in ABS. As I said, during those particular years the system changed markedly electronically, and that made a really significant difference. They are some of the reasons that might explain those trends.

Also, the data may not fully pick up on the issue of particular populations at risk. The underreporting may be selectively biased towards groups that are missing out. There is a universal and continuing problem with certain methods of death—for example, drownings or poisonings—which are very hard to make a call on. That will always be the case. Because women typically use poisonings, maybe there is a problem with female suicides being underreported. Similarly, in small rural areas there is likely to be an underreporting problem. There is also very much a problem that is not so much about suicide but about the identification of deaths as Indigenous or deaths involving a gay/lesbian/bisexual/transgender person. Those are of particular concern too. That is not so much about suicide as about death identification of groups of interest.

There are a number of matters at stake here. You can separate these problems into three domains. The first is information coming to the coroners, the second is coronial processes and the third is data stakeholders. With respect to information to coroners, we have a problem with police reporting of suicide, for instance. There has not been a national system. This has been introduced increasingly by NCIS, and forms are being trialled in different jurisdictions, but not all states have adopted these. Results have been promising but the problem is in actually getting that operationalised in jurisdictions, making sure that the relevant information is on the form and making sure that the police who do this kind of work are skilled up and trained to do it. That is an example of a problem with the information that coroners get.

Coroners themselves have had difficulties because they have a high standard of proof. They have a legal standard of proof, which is not necessarily the same as a research or a suicidologist's standard of proof. They typically also have to deal with not only the determination of death in individual cases but also their public duties as prevention agents. To some extent they have to be facing both ways. When they are considering the needs of families who may have an interest in the suicide not being made public, for reasons to do with stigma or where they themselves might have concerns about that issue—for personal reasons; we do not know much about that, but they are members of the community like everyone else—those verdicts may not get recorded. For example, I had a dear friend, a child survivor of the holocaust, and he had a terminal illness. He was in remission from that illness and his mind was probably being affected by the drugs that he was on. He believed that he could not be cured, despite actually doing very well, and he took his own life. This got coded by the doctor as due to medical causes. His wife was distressed about that, because it was not discussed with her. It was more to do with the way the doctor perceived what her needs might be in the situation. This is just one example of a process that happens all the time.

We have very good reason to believe that it is not only accidental but also intentional that suicides are getting missed in some situations. We do not know how universal that process is, but we do know that it is a major issue. So that is part of the difficulty for coroners. We then have problems for the data stakeholders, some of which I have referred to.

In terms of what we have to do, the overall goal is to get standardised reporting, collection, capture and coding across Australian jurisdictions. That is the overall goal. We have had two meetings now of the National Committee for Standardised Reporting on Suicide. There is certainly a will to engage with this issue, across many parties who are concerned about addressing this issue systematically, and to work together to achieve that. You can read the recommendations that we have in our submission, but we certainly need, I suppose, an overhaul of mortality system reporting in Australia. We need, for instance, a trial of the police form in all jurisdictions, to make sure the information coming in is good. We need to train up the officers and so on. And we need to look at the possibility of improving consistency in coronial processes—perhaps even doing samples of cases using expert reporters, independent experts, who actually review cases systematically and work out what the accuracy of the data is. But we do not want more than one set of statistics. We need a single set of statistics, but we need to bring together all the parties who can bring that outcome to bear.

Senator MOORE—Thank you.

Senator ADAMS—I want to continue on the role of reporting by the media. In your submission, on page 63, there was a very good comment in a personal story from a suburban newspaper editor, stating the difficulties of reporting suicide. I was wondering, with the number of people that you are talking about, how we can do something to perhaps help in that respect. And then there is the use of the internet and whether we have a problem in that reporting suicide has a copycat effect.

Dr Dudley—Thank you for that question, Senator Adams, and my colleagues may also wish to respond. It is true that some journalists tell us that they are concerned that, in a sense, the guidelines around this have been interpreted as not to refer to suicide at all or to avoid suicide reporting. A couple of us were at a workshop late last week around the Mindframe guidelines, and the intent there was said to be to clearly signal a wish to make journalists aware of the guidelines and to encourage them to report responsibly, but no directives were being given in a positive sense, like ‘go out and do this’. So it was more in the sense of what not to do rather than what to do.

We have an interest in this story being a public story. We do believe that safety needs to be observed. We are in favour of the existing guidelines being observed; we believe there is an immense amount of research that supports them and their accuracy. We know that unhelpful reporting in the media can create extra suicides but also that good media reporting, quality media reporting, can potentially reduce suicide rates—there is also evidence to that effect. So we support those guidelines but we also believe that, because of the stigma surrounding suicide, there has been a problem with suicide being swept under the carpet and people, particularly who are affected, feeling that they are in the shadows or silenced, or shunned. We believe that, with their support and their advice, we need to proceed with a crafted campaign that is driven by wide consultation and that begins to address this issue publicly, through public discussion. The issue of individuals reporting suicides in a sensational manner is not the same as a public discussion of the issue, and we think that that is one of the key things that need to be drawn out.

Mr McGlaughlin—If I can reiterate that SPA certainly supports the Mindframe guidelines. I would like use my own experience of when I worked with HIV, basically using personal stories to destigmatise HIV in the community, and the strategies that we put in place at that time. I think we have come to a stage within suicide which is very similar in that we need to use the personal stories, not only for the healing of those bereaved and others who may have attempted suicide but also for suicide prevention. I believe that we can do this within the guidelines.

CHAIR—Senator Boyce, you have one last question.

Senator BOYCE—Following on from this particular conversation, where would SPA think we are at in terms of our journey along the destigmatisation route? In mental health areas I think we can say there is improvement but by no means an end in sight. There has been some work around destigmatising suicide—in particular, as you pointed out, in the media.

Dr Dudley—There is a similarity to and a difference from mental health in this respect. Obviously these areas overlap but, as you would gather, they are not the same. With suicide, there is an interest in not making information publicly available that might be injurious to vulnerable people, and that is what has driven these concerns. There is an analogy in schools based prevention programs where there has been a concern about randomly increasing awareness in schools without actually providing referral pathways or effective treatment. There have been US based studies that have drawn out those lessons or arrived at those conclusions. I think that we have a long way to go, though, with destigmatising suicide for that reason. There is this ambivalence not only about the issue and about people with it, but there is a sense of contagion, social aversion or social exclusion—

Senator BOYCE—Plus you are talking about death, which, irrespective of how it occurs, is not something we are very good at.

Dr Dudley—Exactly. That is absolutely correct, but this is death of a particular sort where there is a sense that perhaps they caused this or contributed to it. There are a whole lot of judgments that are potentially implicitly made, but there is also this other surrounding issue: if we are going to talk about it, will it give people ideas? There is no evidence in a clinical setting that that is the case. Doctors or mental health professionals who do not talk about suicide with people actually end up in deep trouble. It is really important to raise the issue with people at a clinical level. I guess the problem is more at a social level, when you have broad programs. How do you ensure that those programs do no harm? The challenge, in a way, is to widely consult about those programs and to have a great deal of input from those who are going to be on the receiving end, particularly high-risk groups of people, about how they can best be advanced. We have excellent contacts, and so do Lifeline and others of our partners, in amongst high-risk groups and we hope to harness these, but we need the resources to be able to do that.

Ms Riley—If I could just add to that very quickly in terms of where we are on that journey with stigma. We had a forum for our own membership late last year and stigma was one of the issues that was very clearly identified by members of SPA—that we do not even understand what stigma means, let alone how to address it at this stage. So there is a real need to go back and really unpack the term ‘stigma’ and work out what the particular issues are. They are across the community; they are across professions. They are everywhere. We need to take that step back and reflect on what it is we are dealing with before we even try to address it.

Senator BOYCE—Sorry, who was saying this?

Ms Riley—This was SPA membership. We have representatives from various organisations, professionals working within the sector and people who work on or research suicide—a very wide range of people.

Mr McGlaughlin—And individuals with life experience.

Dr Dudley—If you have considered the second national mental health survey, you would have noted that general literacy within the community about mental health issues has increased over the past 10 years since the first survey, but help-seeking has not increased. This is particularly so amongst young men. We were talking earlier about the need for targeted responses. This is just one of the groups. The stigma is alive and well in rural areas and with young men, gays, lesbians, bisexuals and transgenders. There are a number of specific groups where this probably needs to go on to some extent below a level of broad public awareness; nevertheless, these groups need to be specifically consulted to help us to know how to best respond to this.

CHAIR—It seems to me we have the issues around stigma and around mental health but there is also a separate set of issues around suicide as well. We talk about them inter-relating. I know they do, but we need to make sure we are dealing with both those issues through the strategies.

Senator BOYCE—I was not attempting to relate them, just to use the mental health programs as an example of something that has been done.

Dr Dudley—Sure.

Mr McGlaughlin—Absolutely with the stigma in mental health we can see that there are changes in the community, but there is still an underlying stigma and I think we have got a long way to go.

CHAIR—Thank you. We have gone over time again—I think we could keep talking to each of our witnesses all day.

Dr Dudley—We thank you for giving us this opportunity and for your devotion and attention to this cause. We hugely appreciate the effort you are putting into this.

CHAIR—Thank you for coming and sharing with us.

[11.37 am]

BAIRD, Mr Glenn, Manager, Support Services, OzHelp Foundation

GRAHAM, Ms Kerry, Chief Executive Officer, Inspire Foundation

MANGAN, Mrs Cheryl, Manager, Research and Policy, Inspire Foundation

TODD, Mr Keith, Executive Director, OzHelp Foundation

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Mrs Mangan—Together with some young people who acted as consultants for our submission, I was the author of the submission from the Inspire Foundation.

CHAIR—Thank you. I understand that you have been given information on parliamentary privilege and the protection of witnesses and evidence. We have got your submissions; thank you very much. I invite you to make an opening statement and then we will ask you some questions.

Ms Graham—I would like to start by thanking you for the opportunity to address you and also to recognise the importance of this inquiry as a critical piece of Australian policy to reduce the terrible toll of suicide on the Australian community and particularly on young people.

My opening comments will be very brief. To give a short overview of Inspire, we are a national youth mental health organisation, with our reason for existing being to reduce youth suicide. We do this in a particularly unique way. We only use the power and potential of technology to reach and engage young people in ways that traditional services cannot. Our other real point of difference is that we engage young people in every part of the design and delivery of our services—in fact, every part of the operating of our organisation. So we understand deeply how young people experience social exclusion, mental health difficulties and the social and health causal pathways that lead to suicide and we try to harness technology to intervene early in that pathway.

Our approach is based on health promotion and prevention. So we very much work on the social determinants of health and we measure our success by improvements in help-seeking of young people in their social connectedness and what we call their self-efficacy—their sense of agency, their sense of being able to influence the environment around them in a way that improves their mental health and wellbeing or their sense of connectedness.

So in our submission we have put forward some strategies that we hope could be implemented for young people in Australia. We also believe, along with others who addressed you today and through the hearing, that awareness of youth suicide, and particularly awareness of groups at greater risk of mental health difficulties, needs to be raised in the community. We strongly believe that greater social support services as well as health services need to be provided particularly to young people. We are strong advocates of the benefits of new and emerging technologies to bring new ways of tackling old problems and to bring innovation to the suicide prevention sector. And of course we are staunch advocates and an example of the benefits of involving consumers deeply in the ways services are designed and delivered.

We were part of a consortium that prepared a joint submission to the inquiry. Along with those partners, we on a more systemic level across the community believe that a general public awareness campaign needs to be launched around suicide prevention with particular awareness raised around at-risk groups. We share other consortium members’ concerns around data capture and call for an independent and transparent data capture system that informs decision-making, policy and investment. We also call for a new model, a way of nationally coordinating suicide prevention in Australia which is based on whole of government and whole of community.

They are my brief opening comments. I particularly make myself and Cheryl available to the inquiry around technology and its unique position to help address this very difficult issue.

Mr Todd—Thank you, Senators, for the privilege of speaking today. I and my colleagues represent a joint submission but also we represent a particular at-risk group. Though we are not a male only service, 80 to 85 per cent of our client group is in that group, and many of them young men, in the building industry and other industries which we will speak about. I thought I would give a brief overview of the foundation. It started here in the ACT in 2002 and it was a response to three young men dying by suicide in Canberra, which you may have read about. It was actually a passion of the mother of one of those boys who tackled the CFMEU and the Master Builders and they came together in what you may agree is a unique grouping to proactively tackle the issue of suicide in an industry. I come from another male dominated industry, policing. I was in that for 18 years and during that time we lost 16 officers in a small force of 2,300. So I understand the complexities of high-risk groups and male dominated industries.

A pilot program was funded and went on in that time working with men who typically face 80 hours of work a week, issues around relationships, drug and alcohol use, gambling and financial issues. Our program set about tackling those issues because they were key risk factors, as we discovered through our evaluations both by the Hunter Institute and ASRAP in Queensland., and more locally and recently the Men’s Health Research Centre in Sydney. A lot of our research and our evaluation focused on risk-taking behaviours and also help-seeking behaviours. Some of the research found that there was a 75 per cent greater risk of men in the construction industry to suicide.

The program was started with a very medical focused model where myself and another person with the organisation then were expected to scoop up sick apprentices, take them to a psychologist and they were going to fix them. Within two months we have turned it round to become a community-based—

Senator BOYCE—If you had finished the program within two months that would have been well done.

Mr Todd—It was something like that, yes. It was basically a choice that we had of going along with that model or tackling it with what we, the staff, believed was a population health approach and the need for a really community focused model, the community being the building industry. So we set about embedding our service, uniquely, into the industry that we served at that time. A lot of the stuff that Glenn will speak about is focused on building relationships with those men in the industry in any unique way that we can come up with. Again, Glenn will speak about those services and how we uniquely approach that.

The model was developed, and it was successful. The Hunter Institute of Mental Health evaluated it around the areas across the world about building resilience and also promoting good mental health in a workplace—and a particularly unique workplace at that. In 2005 we started a national expansion program following a scoping study that showed that the model we had developed, with adaptations in other, bigger states, could go throughout Australia. We are now in five other states and territories and also in the areas of mining, public service and community, delivering a unique model.

I am going to hand over to Glenn to speak about some of those services, but in finishing I would agree, in both our joint submission and our own submission, that the issue of data is essential for us as practitioners. We need that data to make sure that what we are doing is correct. A lot of our services are aimed at raising awareness, and when you raise awareness you open up the pathways to care and seek either to be a conduit, which we are, to other services out there in the general community or to provide unique services to help men explore their ways of getting help. Again, I would echo that we need a coordinated, whole-of-government approach to see suicide tackled as mental health has been tackled over the years. I would agree that they are inter-related.

Mr Baird—Thanks for the opportunity to speak again. I will give a brief rundown of our services. As Keith mentioned, a lot of the stuff we do is about building relationships. It is a proactive service. We initially started back in 2002. When we moved away from the medical model, we went to a very proactive model. We employ field officers to go out there. Instead of waiting for the workers in the industry to come to us and seek help themselves, we go out there and meet them out on site in the industry to make the step for help as easy as possible.

The way we do that is to focus on apprentices. That has now expanded, with more field officers on the ground, but we initially started focusing on apprentices, so that every apprentice here in the ACT—as a start—was able to get a visit twice a year from an OzHelp field officer. That was about building relationships. Everyone knew what we were about. All the apprentices knew what we were about, so, in getting a visit from an OzHelp field officer, they knew they were going to talk about their mental health, how things were going for them, their coping strategies and things like that. So that really built a strong foundation and that gave us a good name in the industry.

From there, we have expanded our services. We do what is called OzConnect: we go out there on site and run barbecues for one whole building site, which could range from 50 to 100 people. We cook a barbecue out on site. Who knows? The way to a man’s stomach is by feeding him. The connections we are making on site are wonderful. We get out there and talk about mental health. We have 50, 60 or 80 guys—whatever—standing on a site. We can wander around, have a chat with them and let them know about our service. We offer counselling as well. It is great to walk into a group of men, start talking about mental health and then, all of a sudden, have 10 blokes talking about their mental health openly.

Another program that has been really successful is the Tradies Tune-up initiative. This started with a need. We see many guys out on site and for counselling. There was a bit of an issue with physical health as well, and we thought, ‘Okay, how can we attack physical and mental health together?’ So, based on the Pit Stop program, we developed what is called the Tradies Tune-up, and that is run out of a van. We turn up on site in a van, and there is a nurse and a psychologist. We sit inside the van and do 15-minute health checks. We are checking glucose, cholesterol, blood pressure and also mental health—depression, stress and things like that. There is an idea that men will not seek help or talk about their issues. Every Tradies Tune-up event that we run on site is booked out. Every time we are in the van, guys openly talk about what is going on for them. That disproves this idea that they will not seek help and will not talk about their issues. It is about finding the ways that they will talk about their issues, because they will; it is just creating the right environment to do so. So that is a very successful program that we are running at the moment.

On top of the support stuff that we run, we also run the Life Skills Tool Box and a number of different training sessions in that. The Life Skills Tool Box is essentially a 48-hour course on resilience. We are delivering subjects like communication, anger management, conflict resolution, mental health awareness, suicide awareness and that kind of stuff for apprentices and workers in the industry to give them the skills to be able to deal with adversity when it arises. Rather than letting it build up until it is ready to explode, they have the skills to jump on it early and prevent it from getting worse. Those are our services in a nutshell. There is a bit more information in our individual OzHelp submission.

Senator MOORE—I would like to know from both groups how much you are reliant on government funding, whether you have government funding and what the impact would be of not having it.

Ms Graham—Inspire Foundation has been operating for 11 years. For the first nine of those years our government funding was four per cent. We are now at around 25 per cent. That is largely because technology as a setting for service delivery has now been recognised by government, and we have moved from being an innovator to being a leader in the field, which has untapped government funding for us.

Senator BOYCE—Is that state funding, federal funding, or both?

Ms Graham—It is federal. We do receive small pockets of state funding, but, as you would imagine, they are project based. I think one of the untapped advantages of technology is its scalability. Looking forward, I think government funding is quite critical in relation to the scalability of technology to address suicide prevention. That government funding is not just around program delivery; it is around infrastructure. The National Broadband Network is critical to suicide prevention in Australia.

Senator MOORE—I see the point, but don’t people add all the costs of that into Inspire’s funding?

Ms Graham—No. But, equally, there is an ongoing role for government in making technology accessible in terms of cost.

Senator MOORE—So the impact of not having it—

Ms Graham—Is huge.

Senator MOORE—You can see where I am coming from, but I am just trying to get it on record. And your organisation, Mr Todd?

Mr Todd—I will start with the ACT. Our funding in the ACT is 30 per cent from the territory and federal government, and the rest is project based from the construction industry. Certain states have construction industry funding mechanisms but others do not. Where they do, we can seek that funding. We also have corporate support. But I would say that if we did not have the government funding it would be a serious issue.

Senator MOORE—Apart from the project funding for particular things, do you get funding for two- or three-year cycles?

Mr Todd—Yes. Our funding from the ACT government is recurring, but the other funding is normally in three-year cycles.

Senator MOORE—Ms Graham?

Ms Graham—We have no recurrent funding; it is all project based three-year contracts.

Senator MOORE—Would either group like to make some comment on the impact of three-year funding and what happens in the last six months of your operations as your funding gets closer?

Mr Todd—Every time we face that, we face staff losses. We lose good, quality people because they have family themselves. They are probably looking for another job nine months out. They have families to support and they have to take care of their own sustainability. They start to look for other jobs if we hit that point. We have hit that point once. We have been fortunate enough to keep our staff. Our staff has grown from three people in a garage to 30 people Australia wide. We have 20 in the ACT. That includes project we have in the Northern Territory and the far north of Western Australia. I would say that 10 of those staff have been with the organisation for a there for six years. We have been fortunate to get good quality staff, but certainly our field officers at the grassroots level start to look around; they get itchy feet.

Senator MOORE—I meet your field people in Brisbane from time to time and that is certainly one of the things we talk about. Ms Graham, what happens as the cycle of funding gets closer for your group?

Ms Graham—I endorse those comments that have been made. I think the other lens through which to look at that is that things change really quickly for young people—youth culture, youth trends—and things change really quickly in the realm of technology as well. So three-year funding contracts, which are set at the beginning, do not allow a great deal of flexibility to be highly responsive; and then, when you are getting to the end of your funding contract, you are putting most of your efforts into repositioning or demonstrating success, which is very important, as opposed to being as forward-thinking as you can be and asking, ‘What are the next trends or the next things that are happening for young people that our service can respond to?’ So I think three-year funding contracts reduce an organisation’s flexibility. Recurrent funding allows you to be highly responsive in the moment.

Senator MOORE—The other question—these are specific questions about systems, just to get them on the record—is about evaluation and reporting processes. Both your organisations have now been going for a period of time and you have both got specialist areas and evaluation processes—your own as well as those expected by your government funders. Do you have any comment about how they could operate or could operate better? I would think you would both have views about how that kind of stuff could be done better. One of the things that consistently come up is that there are so many projects that start but then die because there is not enough understanding of the outcome that is being sought because somehow evaluations were not effective or sometimes did not happen. In both your areas, do you have any comments about how current evaluations operate; and what are your suggestions about the best form of evaluation for the kinds of services that you provide?

Ms Graham—I think our experience as an organisation may be not unique but different in that we invested in research and evaluation long before we had a government contract that required us to do so—

Senator MOORE—Which you mentioned in your submission, yes.

Ms Graham—We did so because we wanted to clearly demonstrate technology as a setting and there was very little research in the area. Our mandate to contribute to the evidence base and to evaluate our programs is self-imposed. So a government funding commitment that allocates a percentage of your funding to evaluation is welcome, but we still fund far more evaluation and research work than our contract funding provides. To your other question about how it can be done better—

Senator MOORE—Yes; what is the best way to evaluate?

Ms Graham—More action research, so you are getting real-time feedback into your services and the way your services are constructed and delivered. But I also think it ties into the discussion around a national coordinating body—that is, if we can demonstrate success with certain target audiences using a certain approach, that needs to be disseminated and shared very quickly so that other organisations can learn from that or so that it can influence policy. I think the coordination around the breadth of evaluation that is happening is so poor that unless we organise ourselves, as we have been doing, the learnings are lost.

Mr Todd—In our very first evaluation we set up, as I mentioned, a medical thing, and within two months we had to turn it around. So I had to go back to—

Senator MOORE—You had self-evaluated that that was not working.

Mr Todd—We self-evaluated very quickly. We had to go back to our funders and say, ‘This evaluation isn’t going to work.’ Fortunately, we were with the Hunter Institute of Mental Health at that time and we were able to turn it around. I guess from that point we made a decision to focus all of our evaluations—yes, we might have to fulfil government criteria—on action centred research. We have actually got one on Tradies Tune-up that Glen mentioned, which has just recently been completed, with us and we would like to leave that with you.

Senator MOORE—That would be great.

Mr Todd—And we have invested in that ourselves. We get a certain amount, obviously—10 per cent—that should be spent on evaluation in any contract. We tend to spend more and we prefer that because our evaluators also give us steers where it is not going right. So, at the end of three years, it is not a case of ‘here’s a report’ and we give it to the government and it goes on a shelf, and thank you very much. We like to get some value out of it because it is an investment. As Kerry said, there is a need for wide dissemination of things like that. I know that some of the reports we have submitted are still not up on any website. Nobody has seen them. People ask us for them so we give them to them, but unless people know where to go for that information it is useless. It needs to be spread around, because we do not want to reinvent the wheel.

Senator MOORE—Okay. Thank you.

Senator BOYCE—I just wanted to ask about OzHelp and the idea. Do you get involved in training first aid officers in workplaces as well? I am not sure if I am using the right term here.

Mr Todd—OH&S—occupational health and safety officers?

Senator BOYCE—Not the HSOs themselves but the people who would be delegated to individual sites, perhaps to be the first point of call for an accident or something.

Mr Todd—Perhaps I can mention a program that we skipped over there. There is a program we have developed—it was actually developed in Queensland—called Mates in Construction. That is a mental health and suicide awareness program that develops mentally healthy work sites, and they are the sort of people that we are training. That starts with general awareness training of one hour, and out of that we get peer supporters who volunteer their time on a work site. We then give them more training around mental health and suicide awareness, so we have peer supporters and they feed back to our staff, because Queensland is so large. But that program has now been adopted nationally, and they are the sort of people—first aid reps and people who people go to.

Senator BOYCE—Yes, that is right. How long has that program been functioning.

Mr Todd—It has been going a year now. It is being evaluated up in Queensland, and we are also using it in Darwin and now in the ACT and regional New South Wales. So it is—

Senator BOYCE—I must admit that my first reaction to this was that, if I were a first aid officer, I would be quite happy to think that I could do something if I could see a heart attack happening, but how you see that someone is looking suicidal could be a more difficult question for people and create guilt feelings.

Mr Todd—Yes.

Senator BOYCE—Can you talk to that.

Mr Todd—This program raises awareness, and out of that people volunteer. We screen those people. We get some people who obviously volunteer for the wrong reasons to be peer supporters, or ‘connectors’ as they are called in the program. Then there is a higher level of training. But those connectors are then supported by the OzHelp Foundation, so they are given mentoring training and they are given pastoral care themselves to make sure that they do not fall into those cracks that you describe—the guilt feelings.

Senator BOYCE—Thank you. My other questions were to the Inspire people. Why 14 to 25? What happens at 25?

Ms Graham—The young people that use our services do so largely anonymously. They would be—

Senator BOYCE—Do you know they are young people? I suppose that is the question that would come out of that.

Ms Graham—Yes, we do. We ask people who are using our services regularly who they are and why they are there. Just to speak to the anonymous piece, one of the incredibly attractive parts of technology is that you can come online and speak with safety and confidence without having to disclose who you are at that point. If you want to disclose who you are, you are able to, and that is part of your pathway to help. By the time you are 25, our services are providing you with content and interactions on how to access adult services. But, in terms of that handed-over care—if that is what you are referring to—

Senator BOYCE—Yes, I am just trying to see if there is something like, ‘Sorry, you’re 25; get out.’

Ms Graham—No, not at all. It is about targeting. Our services are attractive and relevant to people under the age of 25, so if you are over 25 then you might not find them as useful.

Senator BOYCE—But obviously that is a continuum, not a—

Ms Graham—Absolutely. About 20 per cent of service users are over 25.

CHAIR—Of your services?

Ms Graham—Yes.

Senator BOYCE—Senator Adams touched earlier on that question of bullying and other awful behaviour towards people who are vulnerable through online services et cetera. What are the issues around getting trusted help from the same sort of technology that might in fact be harming you?

Ms Graham—I think the biggest thing about safety is safe online communities, in the same way that, if you are a young person experiencing difficulty through bullying in your offline life, you create safe places. Think of Neighbourhood Watch or places within school environments where young people know they are safe. An increasing number of services, including Reach Out, are providing incredibly safe online communities. Because young people are going to go online regardless—it is increasingly the place where they socialise, where they form identity, where they keep in touch with their friends and, more and more, where they are required to go if they want to succeed in terms of digital citizenship, literacy and employment—there must be safe and supportive communities online where they can go. To me, a far better way of supporting young people to access all of the potential technology is exactly the same way we do it in our offline lives, which is to be upfront about risk, to teach young people how to manage risk safely and to build resilience towards those risk factors. It is a fact that those who are vulnerable in their offline lives are vulnerable in their online lives. So it is about providing very safe and supportive communities.

The things that drive young people to those safe and supportive communities include relevance—they like going there. They have trust. We spend a lot of time building trust around brands. We have more than 75 per cent brand trust. Young people recommend our programs to other young people who are going through a tough time. We have protocols on all of our websites that ensure young people are safe while they are there. And they keep returning. Our other indicator is repeat visitors online. They go there because they know they can get the information they need in a trusted and safe space.

Senator BOYCE—What is next for Inspire? Online technology, SMS et cetera are very established. What fields are you looking at moving into?

Ms Graham—In terms of the evolution of technology, there will be a push to mobile phones. Increasingly, young people will no longer access the internet via a laptop; they will access support and services via a handset. How does a health system and a social support system become relevant to a young person through a handset, and how do you get meaningful content and interaction in that way?

CHAIR—When you are limited to 140 characters!

Ms Graham—Exactly.

Senator BOYCE—You ought to try to answer the questions you are asking, Ms Graham!

Ms Graham—These are questions we are researching as well. I think the other evolution for technology is full-spectrum support. There are pockets of support around treatment going online. There is now proven evidence that you can get a CBT treatment online that is just as effective as—if not more effective than—seeing a professional face to face. You can do it in your own time. You do not have to take time off work. You do not have to sit in waiting rooms and have a disrupted work or family life, and you can do it in the privacy of your own home. What we need to do is get the integration we have offline between health promotion, prevention, intervention, treatment and postvention all coordinated online. Because more and more people are seeking help online, if we have that service coordination it is the next evolution in innovation. If you go to beyondblue for help around something and you get routed safely to a place that meets your needs because it is targeted and you have had online assessments that make sure you get the help you need in a short amount of time, it is service coordination in a whole new setting.

Senator BOYCE—Do you operate in the rural and remote areas of Australia?

Mr Todd—We have just started operating in the Pilbara region in the north of Western Australia.

Senator BOYCE—So you are in a mining area?

Mr Todd—We are in a mining area. We are in the Pilbara and Karratha and we go out into the Tom Price mines. We have been going on that one for about a year now. It has its own unique set of issues. It has fly in, fly out workers. We are developing some different strategies to cope with that sort of stuff and work with those guys. We have just established in Darwin. Eventually we will go out from there into the rural and remote areas.

Senator ADAMS—Senator Boyce has stolen my thunder on Reach Out, because that is the reason I was asking questions earlier about the technology and just how that went. But congratulations on that; it is really good. I hope this is the way of the future, and you certainly will be funded to continue on to bigger and better things, especially now that we can use hand-held devices rather than laptops. I am from Western Australia and I have had a lot to do with fly in, fly out workers. I would like to follow on from Senator Boyce's question as to how the program is going. To put my question in context: because of the rural downtown in the south, a number of farmers are leaving their partners to run their properties while they do fly in, fly out work. We are having a lot of trouble with banks not financing properties. Even when they have 70 per cent equity, they are being turned down. I thought I would sow that little seed because these are some of the people you will be dealing with up there. Could you just expand on what you said to Senator Boyce.

Mr Todd—Yes, certainly. We were approached by the Department of Health and Ageing to establish a program just for six months a while back to see if we could put some services on the ground. We started up with some community services. By community I mean running some stuff for the community because people like BHP and Rio are a major partner of the community there. So working with the communities started to introduce us to the mining industry, which was a relatively new sector not dissimilar to the construction in any way. In partnership with Rio we are providing services out to the mine sites. We are also working in the areas of camps where these guys live, and some of these camps 5,000 men, mainly men. There are women there but it is probably about 80-20 there. Providing services at the camps and some issues of where you can provide some services, information, awareness raising again. One of our programs we deliver is called safeTALK, which we found a very good program. It is part of our Mates in Construction, suicide awareness and gives some skills. We have developed some mine site-specific video scenarios for those. So we started to have an impact into the mines in that way. Certainly Rio have been very open, certainly more recently, flying us around. You have to be honest, the funding up there sounds a reasonable amount that when you have got to pay $2,000 a week to rent a house it does not go very far. So we have had some good input by corporate people who at least take up the corporate responsibility of flying our staff to and from these sites.

One of the key approaches over there that has been successful and has been in all our self-help stuff is partnerships with others, partnerships with the local health service, with StandBy suicide bereavement program, working together because it is such a small community even though it is spread out. Out of that has spun things that we have a public health physician who is about to start to do some research with us funded in their internship, so they are going to do some action centred research in that region. Also we are trying to get Tradies Tune-up by using the resource we have got for free. So it is trying to think outside the box. You have got a small amount of funding which basically covers two staff, and we have been fortunate to employ staff who already have housing. If we did not, we would only be able to employ one. So we have two staff because both of their partners work in the industry. I guess one of the big issues up there is finances but it is also finances for the people are working with. Where we have apprentices, clustered as a social pool here, there an apprentice may be on $100,000 a year fly in, fly out. So they are working with a lot of money and we do a lot of financial literacy. It is quite a high-risk factor, as it has been in construction. It is now a high-risk factor for a different reason in mining, because they have a lot of money and rather than fly home they pop on a plane t Bali. Whilst it is a similar environment, it has its own complexities, and funding up there does not go as far as it does anywhere else in the country, so it is unique there.

Senator ADAMS—Having observed or visited a number of mine sites and talking to the community or sort of social work type people, they are getting up to 3,000, 5,000 mainly men, a Neighbourhood Watch type of program going through there associated with it so that the loners are not going to work and just going into their rooms and not really associating with others. I was really very impressed the last time I was up there as far as physical activity. They really had a check on everyone doing something. I think that is probably part of what you have been doing. It is just so important because it is so easy for them to slip away and be in their room and be worrying about once again finances. That is the reason a lot of the farmers are there, of course—to try and keep everything going.

Mr Todd—That is right.

Senator ADAMS—But the Pit Stop program, as you mentioned, was still going because when it first came out it was that all the rural shows and field days and very popular. But I think now we have got the younger farmers so connected to technology but there is that cohort of probably 50-year-olds on and as these farmers are ageing a lot of them are still working and becoming more lonely or isolated because of technology moving one way and they are not quite keeping up with it. I think that is probably a cohort of people for whom, if you can get them away, the Pit Stop was working very well.

Mr Todd—I will ask Glenn to speak to it, but one of the adaptations we have made is made it less labour-intensive. Pit Stop relies on maybe 10 volunteers and we have managed to hone it down to a couple of staff, who can get a very similar effect.

Mr Baird—The thought so far, to make it happen up there in the Pilbara region, getting access on site is very difficult and therefore trying to get the van or a shed in the camps and somewhere where they can go for a 15-minute appointment and get a very brief overview of their health and the chance to have a chat with a nurse and a psychologist. If we can make it happen, I think it would be a very good way forward.

Mr Todd—Certainly those communities of 3,000 people lumped together from all walks of life have flown in there. The health coordinators on those sites, the social workers and the health coordinators are the people we relate to because they are the ones who set up those physical programs and it is just interacting with those at the same time.

Senator ADAMS—On the Indigenous issues, are you getting interest in that respect?

Mr Todd—We are. In fact, one of our workers is Indigenous. We are also working with Rio. We have developed an Indigenous mentoring program. They already had one and we have enhanced that around mental health and social and emotional wellbeing. So we have been working quite closely again with the existing structures. Rather than being at the wheel, we work with the existing structures, and with some of the communities to translate some of the materials that we have. One of the translations we thought would be language and it has actually turned out to be colour. So we have to adapt our logos, adapt our stuff around the colours that would relate for that particular group. We have had a lot of interest and support from the industry themselves to translate our message in a way that reaches that part of the community.

Senator ADAMS—Good. Thank you to both organisations very much.

CHAIR—I have got a couple of questions. I wanted to pick up on Inspire and your Indigenous programs and how you are targeting that. You talked about high-risk groups and that is one of our particular focuses in this inquiry as well. How are you finding your programs are being accepted and used in Indigenous communities?

Ms Graham—About two per cent of our user base are Indigenous, so we know that the setting is relevant and increasingly relevant for young people. We have done a stack of research around how young Indigenous people access technology now, because there is an urban myth that they do not have access. What we found is that they do, they are incredibly resourceful in how they access—

CHAIR—And also very adaptable. We have travelled in Aboriginal communities and that is one of the things you notice with the kids, that they are straight onto the computers.

Ms Graham—Very quickly. There are particular social networking sites that different groups of young people use and Indigenous young people centre around one in particular, so we are in that social networking site, called Bebo, that we particularly look to target Indigenous young people on. On the whole we think that our universal service is working well for Indigenous young people, but what we want to do as an organisation is become more targeted. Having provided a universal service to young people for 10 years, our strategic change is to become more targeted at young people at greater risk of mental health difficulties and to create safe and supportive online environments so that when they arrive there they feel like it is relevant to them—they see themselves there.

So Indigenous young people will be a strategic target for us. What we are looking for, though, is to be able to access the entire Indigenous youth population. There are significant barriers to anyone who is not in a metro area around access to technology. In terms of the things that will disadvantage Indigenous young people, you have one disparity around access and then your second disparity is around digital literacy. Do you have the skills and resources to be able to apply technology to your benefit? Non-Indigenous people, most of the time, are learning that on a daily basis and Indigenous counterparts are not. So we will need a particular type of strategy for Indigenous young people to benefit in the same way.

CHAIR—I want to go back to the old resources issue. Are you able to access specific resources to develop that new strategy and implement it?

Ms Graham—Not as yet. We have conducted the research to fuel that funding push but we have not as yet been successful.

CHAIR—You have applied?

Ms Graham—No. We will be. That research that I was referring to is hot off the press.

CHAIR—What I am looking at is: are the resources there to target in the first place, and how successful do you think you are going to be?

Ms Graham—In answer to your first question, the resources available for targeting sit under the teleweb counselling measure. I do not know the answer to that. The resources are there, but whether we can access them time will tell. In terms of our strategies to target that population group, I believe that we have innovative strategies to bring to that which will warrant a close look by the department. I can undertake to keep you informed.

CHAIR—That would be very much appreciated. Thank you.

Ms Graham—Certainly.

CHAIR—You were talking earlier about young people recommending your services. Is awareness of your organisation and your services created just through other young people recommending your services, or do you have any other strategies?

Ms Graham—We use social marketing to attract young people to our services. We compete with brands like Coke, Hurley and Billabong, so we use similar tactics. Young people may find us through billboard advertising or through armbands. Increasingly we are in all of the spaces where young people congregate online. Our social networking strategy in the last two years has completely changed the face of the way young people find us. If a young person is on Facebook, in any Facebook site that congregates around a social or health issue we will be there as a user saying, ‘Hey, if you want to learn more about this, check this out.’ It is all about positioning yourself as an older brother or sister who has been there and done that, and it is so important for cutting through.

Senator MOORE—I want to follow up. Do the school based programs that the department funds have a link to your site?

Ms Graham—We have a relationship with MindMatters. It would depend on the state or territory and the delivery. In some areas we have a stronger relationship. It is part of the lack of coordination across the suicide prevention space. We are a very strong natural complement to MindMatters, but they are not required under their funding to coordinate or collaborate with us, so our attempts in that regard are all based on relationships.

Senator MOORE—That could be something we could follow up on.

CHAIR—I delivered seven boys yesterday to an internet cafe so they could go and shoot each other playing Warcraft. That is the one where they all team up—

Senator MOORE—And shoot each other.

CHAIR—and shoot each other. The whole place was full of boys. It was all boys, no girls—not one, other than the mothers delivering their sons. I am interested to know how boys versus girls react to your services and how they access them.

Ms Graham—This is the singularly most vexing question for us. In fact, I would say this is the example of why targeted services are needed generally in suicide prevention but particularly for young people. Our service usage mix on our universal offering, Reach Out, is your standard 80:20. It pretty much reflects the mental health system. Three years ago we developed an online game, called Reach Out Central, to target young men and it won a lot of international awards about a serious game. It is like Sims—if your sons have ever played Sims—you go online, you have 26 characters and you interact to get put in very standard social situations where you have to make decisions that affect your mental health and wellbeing. At the end of the game is a mood tracker. Young men played it like wildfire, but once you have played it a couple of times you have probably exhausted your learnings from it. We have now won an Australian research linkage grant off the back of that evaluation work to understand how young men seek help and how they use technology and to really get in there and exploit that nexus, that overlap. In the next year we will lodge a young-men-only specific service based on the evaluations of that online game. We have just done national focus groups and an online survey with young men to really understand how we can improve their mental health and their help-seeking skills in the places where they already go. Do we have to be in every single one of those gaming environments? Does the home page have to be Reach Out but in a way that is relevant and engaging for young men. As an organisation if we can change one thing in where we are up to it would be to increase help-seeking for young men.

CHAIR—It seems to me that young men are online a lot. I know that young women are too, but my experience with young men is that they are gaming a lot, and the other thing is that they chat to each other. You do not make phone calls anymore; you get online and chat. I had that experience yesterday. I asked, ‘What time are we supposed to be there.’ The answer was, ‘I’ll just ask Sam.’ It was not on the phone; it was real time.

Ms Graham—I think it raises really interesting questions about where the best social outcome can be achieved. Is it talking to the gaming companies and introducing into games a sense of social connectedness or care for other game players that drives points—you win more if you are more socially connected and compassionate towards each other?

CHAIR—While you are shooting the enemy! My experience is that these games are quite violent and it is all about winning. It is an interesting area; I am fascinated by it.

Senator MOORE—How much does it cost to get your connection into places like the gaming—

Ms Graham—I am sorry; I do not—

Senator MOORE—You said that you might have to get into every individual gaming location, every individual game. I would imagine that would be expensive.

Ms Graham—It is, and it is all about influence and relationships. We employ staff whose role is to embed our programs in different settings. So we have one focus on education, one focus on the health sector, one focus on West Australia and one focus on the mobile phone industry, the gaming industry. They are things that are very difficult to fund, because they are about embedding services into new—

Senator MOORE—A lot of it is getting to know and getting the networks but the bottom line will be a commercial transaction.

Ms Graham—Yes, although we are yet to have to pay, other than for SMS; we pay for our SMS support line. It is all on leveraging corporate social responsibility agendas.

Senator MOORE—Putting the hard word on.

Ms Graham—Yes, lots of sales.

CHAIR—I am interested in the issue around providing online support and the issue, which I know is a tricky one, of entrenching isolation. I have had direct experience of this with young people. They sit in their room, particularly if there is a computer in the room, or in the study, if you put it in the study, and they are isolated. I see very clearly the value of the support services, but how do we get away from entrenching even further isolation if they are isolated by being online and then they seek support and counselling services online as well?

Ms Graham—There are a couple of things on that. Part of providing a safe and supportive online environment is information and supports around when you are accessing too much. For example, our online game will not let you play over a certain number of hours. We provide a lot of fact sheets and other types of information to young people about overuse and over-reliance on technology. But it is a fine balance that, as a society, as parents or as health providers, we need to get more comfortable with. To draw on young men as an example, we have a button on the site where you can provide unsolicited feedback. So, if something happens in your use of the site at midnight, you can provide unsolicited feedback. In fact, most of the quotes in our submission were provided through that mechanism. There is an actual story of a 19-year-old young man sitting in his bedroom alone after midnight. He typed ‘help’ into Google and found us. He found the help that he needed in that moment and emailed us at three in the morning to say this is what happened. There is another quote on page 23 from a young woman who went online. She had typed ‘quick easy suicide’ into Google late at night and found a site that actually said, ‘We believe in you. We’re here for you,’ and just that got her through to the morning.

The other massive benefit of technology is that there is a whole group of young people who will get what they need just in the online environment, without ever having to see someone face to face. It is that sense of: ‘I’m connected. I’m part of something bigger. I have real and meaningful connections in this space.’ For those that need more, the technology can help them on a pathway to offline help. It is about confidence; being prepared for a system that is big, alienating and frightening; and having the language to put your emotions in. We already know that young men disclose more in online safe-counselling environments than they do even if they have got themselves to a face-to-face counselling environment. There are some unique benefits around disclosure online that set up the help-seeking journey perhaps in a better way than face-to-face services do.

CHAIR—Thank you. That is much appreciated.

Senator MOORE—Your website is great too.

Ms Graham—Thank you very much.

CHAIR—Thank you so much for your evidence. As you can see, we are all very engaged in this issue. We really appreciate your submission, the time it would have taken you to put it in and also the time that you have taken to come and appear before us today.

Ms Graham—Thank you for your interest and the opportunity.

CHAIR—The committee will now suspend for lunch.

Proceedings suspended from 12.33 pm to 1.33 pm

HICKIE, Professor Ian Bernard, Executive Director, Brain and Mind Research Institute

ROSENBERG, Mr Sebastian Pascal, Senior Lecturer, Mental Health Policy, Brain and Mind Research Institute

CHAIR—Welcome. I understand you have been given information on parliamentary privilege and the protection of evidence and witnesses.

Prof. Hickie—Correct.

Mr Rosenberg—Yes.

CHAIR—We have not received a submission from the institute, but I understand that you have contributed to the joint submission.

Prof. Hickie—There are two: we contributed to the joint submission with the other major parties; we also have a submission from Professor Max Bennett on the neuropsychiatry suicidal diathesis. Max is the scientific director of the Brain and Mind Research Institute.

Mr Rosenberg—It is probably also worth noting, just for the record, that the Brain and Mind Research Institute is a member of the Mental Health Council of Australia.

CHAIR—So you have contributed in multiple ways, in fact.

Mr Rosenberg—Yes.

CHAIR—You know our standard operating procedure, I expect, which is that we will ask you to make an opening statement and then we will ask you some questions.

Prof. Hickie—Thank you. I would like to open by saying how privileged we are to address this committee once again. We are extremely grateful to the work of this committee and its continued focus on national mental health reform and, within the context of that, national suicide prevention. It may seem inexplicable to the senators, but quite frequently in government policy suicide prevention and mental health reform are separated in their actions and in their actual processes. We have lacked national leadership on these issues over a long period of time. The Senate's work in its inquiry in 2006 was a key part of focusing national attention on mental health reform. We are very grateful for that work.

I think it is important to say that the national COAG plan that came out of the set of inquiries and submissions in the period 2005-06 which involved the then Prime Minister and particularly the Premier of New South Wales was a landmark occasion. We are now within one year of finishing that five-year plan. It is much to our regret that the second annual report on the progress of that plan has not yet appeared in the public domain. We are now moving from the process of having had a COAG national mental health plan for 2006-11 back to the situation that preceded that: a series of essentially health-led plans. Now we have an agreed *Fourth national* *mental health plan* which comes after the third and the second, which were essentially put out by the health ministers.

This is a key issue when you come to suicide prevention and the provision of care and think about the extent to which this really requires the whole of the community and all of our governments to be seriously involved. We address issues related to health services because that is the area in which we work, but the wider focus that your committee had was so important in precipitating what we desperately need. Therefore, the leadership of governments, and particularly the national government, in taking these issues forward is again critical. I think we are at a juncture in national mental health reform and suicide prevention of again requiring that national leadership. From our point of view, your committee is one of the few national bodies that seriously monitor this issue on an ongoing basis on behalf of the Australian community. I really want to say thank you for doing that.

In the context of what is happening, our biggest issue, and particularly from an academic point of view, is that you cannot seriously undertake health policy analysis or health investments unless you count the outcomes. I am a very simple doctor at heart. What we traditionally do is count the number of premature deaths or the number of people living with a disability with the particular conditions in which we are interested. From my point of view, it is a national catastrophe that we have not had accurate suicide figures since approximately 2005. It is inconceivable in any other major area of health care, if you are talking about cancer deaths, HIV infection rates, cardiovascular deaths, not to know that critical issue and not to know something about a situation where approximately 2½ thousand Australians die every year. The fact is that there is a discrepancy between the ABS figure of 1,800 and the projected AIHW figure of 2,500. Having a 40 per cent discrepancy between the two major issues just means that the area is totally uninterpretable currently.

This is a major area of health reform. It is important to say that this has been a focus of national government activity since 1993, since the first National Mental Health Strategy. The first National Youth Suicide Prevention Strategy was in 1995. To have not sorted out a way of accurately collecting national statistics, to have not invested in the research infrastructure, to have not gone to the other issues which flow from that, like data linkage and accurate reporting across services, to not have moved to the registry type approach, where those people who receive services are tracked for the outcomes—that is, whether they are alive or dead—at critical periods afterwards is inconceivable in any other part of health. And for that I think we all stand condemned. We have failed to put in place the key processes.

In terms of taking this issue forward, we do not think that you can proceed, and no-one who is involved in health reform, academic analysis and policy analysis can proceed, without that information. I would like to highlight the importance of having that available. I was associated with a particular research undertaking which was published in the *British Medical Journal* in 2003, with Wayne Hall as the first author, which looked at the key issue about access to treatment for depression in Australia and suicide rates. It was able to show over the previous decade a fall in suicide rates that was proportionate to the access to care. We were able to do that because over a certain period there were moderately accurate suicide statistics—or accurate enough. There was also data available, in part from the pharmaceutical industry and in part from primary care, as to what was happening. From that we could draw a very important lesson that was published internationally. That work has been repeated elsewhere. It shows a key finding that access to care, to treatment, has a critical effect on national suicide rates.

That has been debated for many a long year in the suicide literature—how much providing care actually matters. It matters. We showed it first in Australia. It has been replicated internationally. We cannot repeat that work currently; we do not know. The situation may well have changed. What we do know is that access to care, despite all the government efforts, has not increased in this country. The access to care, as shown by the national survey in 2007, was that 35 per cent of people with a mental disorder received care. In 1997, 38 per cent of people with a mental disorder received care. While the surveys are not exactly comparable, the basic bottom line about access to care tells us that no-one else is receiving access. The last survey is particularly important, because only 13 per cent of young men and 30 per cent of young woman who had a mental disorder received any care.

If we are serious about suicide prevention in this country, we first need to know the numbers. Second, we need to continue to examine the relationships between access to care and the reduction in those particular sets of issues. What is clear from the international suicide literature is that contacts with care are extremely common in people before they attempt suicide. We have not moved to national tracking mechanisms of those who present to any of our care services and their outcomes with regard to the most simple thing in medicine: are you alive or dead at a reasonable period after access to care? It is inconceivable in any other area.

So, in a series of recommendations that we have made—my academic colleagues from the Brain and Mind Research Institute, with the Mental Health Council of Australia and with others like Professor Pat McGorry—in articles that we wrote in 2005 and 2009, we said, consistently with the COAG national plan, that the No. 1 indicator needs to be the suicide rate. We need to have targets with regard to the reduction in the suicide rate. We need to have targets with regard to reductions in youth suicide in particular. Then we need to track those particular issues and, particularly in a country like Australia, we need to track those who have contact with the health system through its emergency departments, its primary care services and particularly its specialist mental health services.

We have seen a complete lack of will in the health systems to join up occasions of service with the key outcome of care: are you alive or dead at three months? Are you alive or dead at 12 months? If dead, what is the cause of death? They are the simple things that we need to know. We do not need endless reporting of endless activities without knowing whether they have any impact on the key indicator in this particular situation. Just as with national HIV infection rates or national breast cancer rates, it would be, frankly, ridiculous to have any discussion about whether programs made a difference without knowing those key figures, but that is the situation we have arrived at in Australia in 2010.

Mr Rosenberg—I will very briefly add something to Ian’s comments. I was involved in the preparation of some aspects of the joint submission, which I think is No. 65. One of the things which really struck me was how swiftly the participating organisations were able to gather a library of stories. Within the space of a couple of weeks, I think there was a catalogue of something like 200 or 250 stories. These were people who were willing to share their experiences of suicide or surviving suicide. I guess we are dealing with a vital issue which affects a huge number of Australians. To that extent, one of the key statistics, which I think is most salient in our considerations here today, is that, while the number of deaths is at issue in terms of the way things are counted, the Australian Bureau of Statistics is able to suggest that something like 65,000 Australians attempt suicide every year, which is 178 Australians a day or one every eight minutes. I found that an absolutely staggering social, health and economic problem, and it is what principally fires our interest in being here today and trying to improve the situation, particularly for people who have already given themselves a predisposition, if you like, towards suicidal behaviour.

CHAIR—Thank you. I have a whole series of questions, but I want to ask one in particular. You talk about the lack of will of agencies. Could you go into a little bit more detail there.

Prof. Hickie—Yes. We have endlessly interacted, in my previous work with the Human Rights Commission and the Mental Health Council of Australia in the *Not for service* report, with state and federal agencies who continuously do not want to agree that reducing the national suicide number or having a target is a way to proceed; secondly, they do not want to track the relationship between a presentation to a service and an outcome.

I will give you a particular example. I am involved in audits of deaths in services in which I work and I have had the statutory authority in various states say, ‘Well that death has occurred outside our particular two-week limit for investigation, so we are not interested in knowing what happens.’ We have continuously raised with national bodies, including with those responsible for what is now the *Fourth national mental health plan*, that we have got to have the national suicide rate and the total number of deaths that occur. You do not want to count just those that are ascribed by the coroner; you want to be able to count accidental deaths. The ridiculous thing we have in our national health statistics is that suicide is not put with mental health; it is put over with accident and injury, so it is easily confused with road traffic deaths and other unexplained deaths. You want to know in key areas, like those who have received mental health services, whether they died from something a coroner called suicide or in a single traffic accident or by some other mechanism that is also likely in some way to have been contributed to by their problem.

Those issues are absolutely fundamental. These fundamental outcome measure are in agreement. We now have a new *Fourth national mental health plan*. It has 34 areas of activity. It does not have an agreed set of national indicators. It is still not clear that reduction in the national suicide rate is a priority. There is no commitment to actually knowing within three months or 12 months for those who have received state services whether they are alive or dead. These are data tracking issues. Through some of our national research infrastructure, we are investing more in data linkage in every other area of health. In cardiovascular health, cancer health and every other area of health we want to have that fundamental linkage so we understand the way in which different diseases and different outcomes actually occur in our population. We have never received such a commitment. There have been endless inquiries by the upper houses of most of our state parliaments and by auditors-general saying that you would think in health this would be the fundamental area of concern—whether people are alive or dead. There is a great reluctance in this whole area of mental health services. Mental health services reform is typically run as a separate activity to national suicide prevention. There are separate sets of national advisory committees and separate sets of activities going on.

So it is one of those issues where it is fundamentally not being treated in the same way as cancer deaths, cardiovascular deaths or HIV infections. It is not seen in the same way. Sometimes it is seen as too complex and too hard to know. In fact, the greater the degree of complexity, the more people agree that you need to have simple outcome measures and then see what effect those measures have over time. Obviously, you need to have research investment in those areas and more serious analysis of the reporting of that data if you are to understand national trends. But we have done that when the data is available, as we previously did with our colleague Wayne Hall. You can actually do those things. The data in Australia does exist in a variety of different places if you are prepared to actually link it, if you are prepared to actually see it as a priority to understand the system in which you are functioning.

Mr Rosenberg—The system for that data gathering is so fragile that decisions made by individuals can have a massive impact. I am on the Prevention and Community Health Committee of the NHMRC and it recently came to our attention that the Victorian coroner is now refusing to submit information to do with births, deaths and marriages to national data sets, which means that the capacity to link information across cohort studies, which concern not just mental health but a whole range of other things such as cancer registries and so on, is at issue.

CHAIR—Do you know why?

Mr Rosenberg—No, we are trying to investigate why—

CHAIR—We will be in Melbourne on Thursday.

Mr Rosenberg—I think it is a really good illustration of the fact that the whole system relies on extremely fragile foundations when we are dealing with things which have potentially the gravest impacts on the Australian community.

Prof. Hickie—It is fair to say that historically and culturally in Australia our divided federal system has done that. Each system can decide separately. If you compare that, for example, to the Scandinavian countries, which have always used their national data to drive evaluation of their health system and its key priorities including very much in the mental health area, you get different outcomes in these areas of concerns about suicide, concerns about mental health and concerns about interpretation. But they are all the reasons why you have to have national focus and national leadership on the issue to get agreement, to get coronial standards agreed and to get categories agreed, and why you cannot have the Australian Bureau of Statistics actually go forward in the national discussion about reported major reductions in suicides if it is not the case and if it does not stand up to even the most preliminary analysis. From my point of view, that is a national leadership issue. Fundamentally it resides with the national government and with the minister of the day or the Prime Minister of the day to take responsibility for these issues. These are areas of major government investment and programs at the national and state level. To not know the basic outcomes in terms of effects on life and death is inconceivable in any other area of health care.

Mr Rosenberg—Just for clarity’s sake, what we are talking about in particular is what we listed as recommendation 3.2 on page 24 of submission 65, which talked about the notion of establishing key data elements in a robust framework for measuring and tracking suicide over time. That is made very clear in the specific measures which we listed on page 131 of that submission. There is a two-page table, and you can see that the first couple of items are the suicide rate and the death rate within three months and 12 months of discharge from a facility. The last one is the percentage of the population receiving mental health care. Again, these are all matters about which, somewhat amazingly, as 1993 was the first National Mental Health Plan, we still do not have robust, independent, validated measures for.

Prof. Hickie—I think that the senator’s question, though, is: why? It is not as if the community—and I would say we represent that today—and the academic industries have not been calling for those things; they have, continuously.

CHAIR—Yes. I am struggling with the question: why aren’t we doing it? It seems to me to be a fairly obvious thing that needs to be done.

Prof. Hickie—There are some very good examples in other areas, the alcohol and drug area being the best example. I am sure David Crosbie would have shared that with you this morning.

CHAIR—Yes, we did talk about—

Prof. Hickie—They faced the same lack of data in the early 1990s. They developed mechanisms such as the national household surveys and other really complex ones, such as understanding the uses of particular drugs on the street—things that people would not think would possibly be able to be tracked. They have worked out mechanisms to track availability, price and usage, and national surveys reporting on them. So the more complex the issue, the smarter you have to get. You have to invest in it, and you have to be committed to the annual or appropriate reporting of those issues.

In our area we have not seen the same investment in independent research, we have not seen the same investment in accountability and we have not seen a genuine relationship with the community in reporting back progress or no progress on these issues. Key things happen, like the global financial crisis, which would be expected from historical trends to impact on things like suicide rates. We do not know. Suicide rates in young people have gone up elsewhere in the world since about 2005. We do not know whether that is the case in Australia. We just do not know. This not knowing seems somehow okay in our country in this particular area of health. It is not okay in other countries and it is not okay in other areas of health.

Mr Rosenberg—The other aspect, when it comes to comparing and contrasting developments in the alcohol and drug sector, is this purposive investment in independent research centres which are able to operate as an engine to gather and validate information to inform public debate and to inform, frankly, public spending. That makes a huge difference to being able to make astute decisions about what works and what does not work in alcohol and drugs. That has been a 20-year investment in infrastructure, which Ian Webster has written about, that has made a palpable difference to the capacity of the alcohol and drug area to fund the things that work and defund the things that do not work. That piece of infrastructure is missing in the mental health area.

Prof. Hickie—They are fundamentally outcome measurements. Health systems give us activity measurements which, frankly, provide little real insight into the situation in the Australian community.

CHAIR—Senator Moore?

Senator MOORE—There is no real need to ask questions—you got most things on the record there. But, in terms of the process, the way you have outlined it is that we have the data and we have things that are operating but they are just not talking to each other. Is that too simplistic?

Prof. Hickie—There are certain bits of data that are not collected. There has not been a commitment to standardisation because a lot of this is tied up at a state level. It should have been an issue of national leadership to get standardisation and then national accountability. You are, frankly, the only national accountable measure. You hold public hearings; you put focus on a particular issue. You are currently the national community measure in this conversation.

Senator MOORE—We will try not to feel pressured by that!

Prof. Hickie—It is great that the Senate has continued its interest and is actually interested in mental health and suicide prevention. There are two issues. There is getting the right measures. Then there is publicly reporting those and having a national focus, because these issues need to be sorted out across our states and territories. To have certain states just drop out, underreport or choose not to participate is unacceptable at a national level.

In respect of what is then done, the issue of tracking, which I am really emphasising, it is important to say that a country like Australia is not like another country that is in a middle of a war, an economic crisis or other social factors which change suicide rates rapidly. When we have a relatively stable society with relatively stable features, access to care is critical. So in Australia tracking the course over time of those who present to a care agency, particularly a health agency, with an attempted suicide or with a disorder that is likely to lead to suicide is absolutely critical, whether it is to an emergency department, a primary care service or a state mental health service. What has really been highlighted in our system is about knowing what happens to those people. Are they alive or dead?

Then what you get into, of course, is that the services do not want to be held accountable, because typically they provide very short episodes of care—one-off in a primary care situation, a few days in a hospital ward, a few hours in an emergency department—and they do not want to be accountable for the outcomes in those particular areas. But we all need to be accountable for the outcomes of those systems.

Mr Rosenberg—On that table that I was referring to on page 131, there is a list of different data items, and it would be entirely wrong to suggest that that data is available now. There has not been an investment to collect that information, there has not been an identification of what the priorities are for data collection; but the one in particular which Ian was just referring to is patient follow-up in the community. This gets back to the issue about the 65,000 people who attempt suicide. What on earth happens to this cohort of Australians who have some connection with the health system at the time when they are recovering from their attempted suicide, and disappear?

Senator MOORE—And that data is in the hospital base, because that is entered—

Mr Rosenberg—The data of their interaction with the hospital system would be in the hospital system. What happens to them when they leave the hospital and they go back to the community, back to their families? To what extent are they seen by a GP in the days and weeks following? To what extent is there an outreach service? We know the answer to that, I suppose, which is that there is unlikely to be any outreach. But to what extent would they have, for example, an interaction with an NGO that might be able to provide them with the support they need to live well in the community? None of that information is available, so again you have got a large cohort of Australians; this is not something that you can easily miss—65,000 people—but they disappear from the radar, which means that they are in the situation where they are not followed up, not tracked, they are likely to be isolated and perhaps likely to have a repeat episode.

Prof. Hickie—To pick up Senator Moore’s first question, linking data is also important. For example, out of the group that Sebastian has just listed, those have been emergency departments. What proportion of those go on to access services under, for example, the new Better Access program? Through data linkage you could find out. We suspect that many of those people are not the people who receive services under the current Better Access through primary care type mechanism. They could. Or to what extent would they receive services if the ATAPS program—which the minister has announced a review of but has not yet released the report from—were to be specifically targeted and followed up? We could find out. We could follow these things in addition to knowing the actual outcome. We could see how people moved between the sets of services that we have if we actually linked those data sets. Then if we rewarded assistance, for actually encouraging people to use the different available systems, and we rewarded episodes of care rather than just events of service, then we would start to see whether those programs actually had an effect. We are constantly putting financial incentives in the way of providers of care without requiring any improvement in the actual process of care as a consequence—or whether they are picking up the populations who have the least access and currently are at greatest risk. So there is a disconnect constantly between the data that is needed, the data that is there—which is unlinked—and the health initiatives that we keep introducing to respond to those problems. The common feedback cycle that you would hope to see in any evidence based policy system is not in place in mental health.

Mr Rosenberg—To be fair to the Department of Health and Ageing, they have put a lot of money into this area, in the suicide prevention program, over quite some period of time, and I think it has resulted in myriad programs and services that have been put in place. The question is: what impact have they had on the community? Was there a target set to start off with on reducing the rates of suicide as a result of this intervention, and what was the follow-up? I am not sure that there are answers to those questions. Instead what you have got is a lot of activity occurring but potentially it is hard to link that to a real outcome and a real change in the trends on suicide.

Senator MOORE—The department’s submission has listed a lot of programs and activities that have been funded, and we will be asking questions. I have lot of questions, because I have never seen most of this stuff before. They have got one called the Community Connections Project, which seems to be a start, in New South Wales, of 81 consumers who have actually been tracked between 2007 and 2009. It seems to me that that is the way you describe it.

Prof. Hickie—Exactly—

Senator MOORE—I do not know what has happened after 2009, and I will be asking that question.

Prof. Hickie—It is interesting what you say about the activities, because another critique of the whole national suicide prevention strategy over a long period of time is: has it invested in things that work? Minister Roxon, to her credit, when she became the minister put a focus on the need to target the strategy in this country. We are not one of the high suicide nations. We know that a lot of the suicides occur and people are presenting to care, we know they occur in certain demographics and in certain populations. The issue is: do we use strategies which actually reduce or prevent suicide, and are we targeting those in the right ways?

Rather than just having a large phonebook of activities, each with 81 consumers or 52 consumers or a project in another small area, there is an issue of national focus within those sets of activities. It is well-demonstrated worldwide in many reviews of suicide that access to the healthcare system and then tracking through the healthcare system are two of the most evidence based strategies for reducing suicide, once you have done a lot of the other things that Australia has already done—reducing lethal means and a series of other social activities and social cohesive activities. There has been a lack of focus. Much of that is put over in the mental health reform basket and treated as a separate set of issues for which it is not seen that reduction in suicide is a key target. Very few services in the country will actually say that reducing suicide is a target of their activity. There are good US examples that actually set a zero suicide target for their mental health services. They say to their mental health services: the one thing we want you to do is reduce suicides. No-one in this country is prepared to say that to a mental health service system.

CHAIR—Why is that?

Prof. Hickie—Frankly, you may be held accountable. You may show that it goes down, and then it goes up again. It is a continuous quality performance indicator. It is much easier to record activity in a health system. We all know about surgical waiting lists, operations done and people seen. Governments of all persuasions will tell you more about the number of services provided each year than whether those services achieve the key impact. If we know that 13 per cent of young Australian men receive no service at all, we do not need to know about activity. We need to know: are we getting to the populations in greatest need? Then, when we get them or have any contact with them, are we actually seeing them through a very high risk period, which we know runs great risks for those particular young people?

Senator BOYCE—Is there any sense that community attitudes towards suicide could be in part responsible for the lack of focus and leadership that you are talking about?

Prof. Hickie—I think the opposite is actually true. If you look at Australian attitudes to mental health over the last 15 years—and I spend a lot of my time on international comparisons to the UK, the United States and elsewhere—you will see that they have changed remarkably. We have good evidence about that from several national attitudinal type surveys. Suicide is such a sensitive and difficult topic. There is an issue about whether it is being reported in the same way by coroners and whether there are other issues that are taking place. That is an important issue. Frankly, the Australian community is more straightforward about mental health issues than just about any other Western country. I think the reluctance is much more in the formal institutional systems, which may include the coroners office because of sensitivities with families, but also within our mental health systems. There is a reluctance to say: someone died via suicide while under our care and we will be held accountable for that system.

Mr Rosenberg—I think things like the speed with which we gathered these stories, the willingness of people on the *Insight* program the other day and so on are terrific and accurate mirrors of the willingness of the community to be engaged, to share their stories and to work with decision makers to improve the services which are available to their family members. So I agree very strongly with what Ian said.

Prof. Hickie—In most of the community work we have done, the community would say the No. 1 priority in national mental health reform is reduction in suicide. Not only is the loss of life for the person involved traumatic but suicide is so traumatic for the family and the community affected. The community assumes it is our No. 1 priority.

Senator ADAMS—What do you think about access to mental health services for people living in rural areas? Younger farmers seem to be accessing services through technology, but the cohort of farmers who are getting older, who are often working by themselves and who are in the 50 to, say, 70 age group seem to be a little bit lost.

Prof. Hickie—Sadly, as you know, access to health services in general across rural and regional Australia is extremely difficult. The mental health area has always been traditionally difficult to access. In our work with rural communities I think what is clear is the willingness of rural communities to talk about these issues and the devastating effect of suicide on many of those communities. So they are often the communities who have wanted the greatest community action. It is often an area where we in the health system have let people down to the greatest degree. Even those older farmers who are seeking help will have great trouble accessing help through the lack of primary care services and through lack of additional allied health services. While we have continuous emphasis on improving that access to care there are issues related to geography, to money, to availability and then to a failure to invest in new technologies or in new ways to do things.

In addition to everything else we say in mental health it is important to say the national investment in mental health is still extremely small. We have argued for real affirmative action in this area. If you want to put this part of the health system right not only do you have to put new money in but you have to put it into new systems that actually work—a simplistic fee-for-service system does not really work in the country. A failure to invest adequately in e-health is not going to help people in rural and regional areas. In actually working with communities in a productive way with the people who are there you have to find smart ways of working with rural communities and not just rely on the traditional systems.

Mr Rosenberg—When I worked at the Mental Health Council of Australia we put together a brief analysis of the take-up of the better access program and tried to look at metro areas versus regional and then rural and remote areas. It is fair to say that rural and remote areas were finding it as difficult to access as they were any other kind of Medicare funded service. Much of it is to do with the cruelty of the Medicare health professional demographic spread, if you like, but it means that even when you have programs that you are attempting to target in critical populations, they are still missing out. I think what you say is very true and people, particularly in the non-metro areas, are very vulnerable and when it comes to issues of suicide I think that those problems are acute.

Senator ADAMS—I think the hardest part is, of course, the solo GP, if you are lucky, and then for everything else the books are full so where do you go? This is something that is an immediate thing it is not like, ‘We’ll see you in three weeks time.’

Prof. Hickie—I think it is an important issue. A lot of general practice is based on the idea of see you in three years time—that was a slip—in the country three years time if you are lucky or three weeks time and there is a misunderstanding. That is not a health system that works for people who are suicidal—the come back if it gets worse approach. That is a lot the assumption under the triage systems that run. The national youth services, I am associated with headspace et cetera are associated with trying to find new pathways of immediate response. The notion that you can use the traditional primary care system which has those three-week or in the country three-year delay systems will not work. It is a mistake to think simply rolling out more money under the existing systems will help yet that is the approach particularly the federal government largely relies on—those traditional approaches. They least serve.

We did work this year again with University of Queensland with Andrew Page and the *Medical Journal of Australia* about access to treatment for depression and the worst of course is in rural and remote areas of the country unexplained really by other sociodemographic factors. This is a health provider problem of access, it is also when we get new money, we need to spend it in smart ways and not in ways that we already know fail. Much of our criticism of national mental health reform is that it puts new money into old failed systems again and again and then is surprised at who does not get care, who misses out and the lack of impact on basic issues like access.

Mr Rosenberg—So you are talking about a different model of care to the waiting until things are acutely unwell and then going to see a doctor and receiving care. You start talking much more about a paradigm of prevention and promotion.

CHAIR—As I say, it is about health promotion, isn’t it?

Mr Rosenberg—That is right. It is about pursuing people. Once they have been, if you like, fixed up after their attempted suicide they then go back to the community. What is done out there then for that cohort of people to keep them well and to preclude them from considering suicide again or from actually actioning that? Again, you start talking about different systems of care—I think Michael Dudley may well have spoken to you about things like postcards and other arrangements whereby health service providers are proactively contacting people when they are well in order to promote that wellness and to keep that wellness. It makes an awful lot of sense not only from a health point of view but also from an economic point of view because you are then obviating the requirement for a cycle of acute care, danger and so on.

Prof. Hickie—A key aspect of that is that we know that attempted suicide often occurs early in the course of illness, not late. It is often the way into the system, not a consequence of years of poor treatment. So in fact it is absolutely critical that notions of early intervention and suicide prevention actually go together and that you seize the opportunity if ever it arises of an attempted suicide and, certainly for young people, it remains sadly one of the principal paths into care. They are the people you must not lose over the ensuing two to five years; you must know what happens in order to really reduce that risk. That can be the same with the onset of depression in later life or at any other stage, it is that early phase which is often associated with attempted suicide and sadly in older men with completed suicide. That is our opportunity to get in early. We cannot not take that opportunity.

Senator BOYCE—We have not yet, during this inquiry, mentioned the issue of child suicide. Is there any specifically different way that we should be looking at this area, in your view?

Prof. Hickie—I think the general issue is that, fortunately, child suicide in most of the community remains a relatively rare event, although it is absolutely tragic when it occurs. That probably reflects issues related to brain development—

Senator BOYCE—Are we confident about that, I guess?

Prof. Hickie—Like all the things that we think we know, this becomes an issue of monitoring in this situation. They are all the issues we need to be looking at—all the deaths by accident, injury and misadventure across the life span. In terms of the illnesses associated with suicide, we know that they peak in the early adolescent and early adult period and are associated with increasing rates of attempted suicide in that particular period. But your point is a fair one. Certainly in some of our communities—in some of our Indigenous communities, in communities that are really struggling and in some groups that are particularly affected by family separation or by community breakdown—they are issues we need to be extremely careful about. But that becomes then just an extension of the national monitoring issue. If we do not know what is happening to most of the population, you can imagine it is fair to say that we do not really know in some of those particular situations, although my own view is that it would still be a relatively rare event.

CHAIR—Thank you. As per usual, we have run over right over the time of each of our witnesses. We very much appreciate your time and your evidence.

Prof. Hickie—Thank you.

Mr Rosenberg—Thanks very much for the opportunity to appear. Good luck.

[2.13 pm]

BISHOP, Professor Jim, Chief Medical Officer, Department of Health and Ageing

HARMAN, Ms Georgie, First Assistant Secretary, Mental Health and Chronic Disease Prevention, Department of Health and Ageing

KRESTENSEN, Ms Colleen, Assistant Secretary, Mental Health and Suicide Prevention, Department of Health and Ageing

WINKLER, Ms Deborah, Branch Manager Mental Health and Autism, Department of Families, Housing, Community Services and Indigenous Affairs

CHAIR—Welcome. The committee has invited the departments to the hearing today to provide some background information on this issue. The committee intends to invite the departments to speak at another hearing. As we usually do, we will get an information session at the beginning of our inquiry and then ask you back at the end to ask you all the questions we have accumulated over the period of the public hearings. I am aware that you are all pretty experienced at this. You will have been given and know the issues around parliamentary privilege and the protection of witnesses and evidence. As departmental officers, you will not be asked to give opinions on matters of policy, although this does not preclude questions asking for explanations of policy and factual questions about when and how policies were adopted. We have before us your very extensive submission. Thank you. Would any or all of you like to make an opening statement before we ask questions? I know the senators have got lots of questions for you.

Ms Harman—I would. I will make it brief. We welcome the opportunity to come and talk to you today. I am glad you found the submission comprehensive; that was our intent. I just want to give an overview of the National Suicide Prevention Strategy and its relationship to some significant mental health initiatives that also have a strong suicide prevention effect. I also want to discuss some of the reforms of the strategy that have occurred in recent times.

We all know that suicide is a serious problem in Australia, with official ABS data recording 1,881 deaths by suicide in 2007. We know that these official numbers under-record suicide in Australia and we are glad to participate in the work being done by the ABS, Suicide Prevention Australia and others to improve the accuracy of suicide data and to learn as much as we can from the available data.

From this data we know that the fall in numbers and rates have not been universal across the whole population. For example, there is evidence that the rate for Indigenous people has remained the same over the period. Also, we believe that numbers relating to suicide of young men from lower socioeconomic backgrounds have also not reduced at the same rate in the last 10 years. The department is concerned about sustained high rates of suicide for some groups and about people living in rural and remote Australia. Finally, mental illness, as you would have heard this morning, remains the single biggest risk factor for suicide. DoHA considers, as do most Australians, that the number and rate of deaths by suicide remains unacceptably high and that more work needs to be done to further reduce them.

Currently, there are four elements to the National Suicide Prevention Strategy, which together provide policy, program and planning guidance to our work. The first of these elements is the Living is for Everyone, or the LIFE Framework, which provides an overarching policy framework that articulates action areas and agreed approaches to undertaking suicide prevention activity. The second is the National Suicide Prevention Action Framework, which is a time-limited work plan that guides the activity of both the department and the Australian Suicide Prevention Advisory Council. States and territories have their own work plans which, in all jurisdictions, are now linked to the LIFE Framework, which is an important development. The National Suicide Prevention program is the third component and that is the ongoing funding arm under the strategy. This program makes approximately $22.1 million available this financial year, 2009-10, to specific suicide prevention activities. Finally, alignment between Commonwealth, state and territory governments' suicide prevention activity is being progressed to better coordinate investment and activity across governments. This is currently being pursued through the relevant actions of the *Fourth national mental health plan*, which was launched by health ministers last November. We have already started actively undertaking that work with our state and territory colleagues.

The department concedes that there has been confusion about the scope and meaning of the National Suicide Prevention Strategy and that the term has sometimes been used to describe one element or another, so I thought it was important to point out today that there are four components that collectively form the strategy.

The Australian government invests in a broad range of suicide prevention activities. They have been built on a continuum from universal activities to engage the whole population through to selected interventions for population groups at high risk and indicated interventions for people at immediate risk of suicide. Given that individuals with mental illness are as much as eight times more likely to suicide than the average Australian, efforts to expand access to mental health services and to enhance the capacity of these services to detect and respond to suicidal people are very important. In this respect our investment in mental health is also seen as an essential arm of our suicide prevention activities.

Increasingly, effort and investment have become more targeted under the strategy. We have, increasingly, targeted the responsiveness of the program to the needs of individuals who are at greater risk of suicide. Examples of this are Access to Allied Psychological Services, ATAPS, a suicide prevention pilot that provides intensive psychological support to people who have been referred by an emergency department or a general practitioner following a suicide attempt. Additional suicide prevention training has been made available to allied health providers and other primary health workers delivering services under the Mental Health Services in Rural and Remote Areas measure. The strategy has not remained a static strategy. It has developed over the years and, as I alluded to earlier, there has been a shift towards a more targeted approach to suicide prevention activities to those particularly at risk.

The National Youth Suicide Prevention Strategy began in 1995 and was specifically targeted at the problem of youth suicide, which was at that time presenting as a particular problem. By the late 1990s, a review of the youth strategy revealed that many of the universal approaches adopted in that phase should be made more generally available. Thus, the National Suicide Prevention Strategy was developed with a more general, universal approach to suicide prevention. That approach was revised in the 2006 evaluation of the strategy, which recommended that a more focused approach be adopted. Since then, the strategy has increasingly focused on selected and indicated approaches to supporting population groups and individuals at higher risk of suicide.

A full evaluation, which will be independent, of the National Suicide Prevention Strategy is planned for the 2010-11 financial year, and that will provide guidance on the currency and efficacy of the strategy that will inform the department’s advice to government on any changes of direction or amendments to the strategy. The evaluation process will also draw heavily on the project data that is collated by state and territory offices of the department in the management of funded programs.

As I touched on earlier, the Commonwealth, along with the states and territories, has been aware that there has been under-recording of suicides for some time, and this has been a matter of concern to us all. We have been working with the ABS, the National Coroners Information System, Suicide Prevention Australia and other key stakeholders through a number of processes to improve the accuracy of suicide data. The ABS noted in *Causes of death, Australia, 2007* that suicide numbers are likely to have been under-reported for many years. I think you heard some evidence from SPA this morning to that effect. The ABS has announced that it will revise its data commencing in the 2010 release to rectify some of the largest sources of distortion. This will improve the accuracy of suicide data, and we are expecting that the published numbers for 2007 will increase as a result of this revision. The revised data is due to be released on 17 March 2010.

It is imperative to emphasise that, in the area of suicide prevention, there is the capacity to do harm—to unintentionally cause harm to those bereaved by suicide or even increase rates of suicide—without a very measured, evidence based approach to suicide prevention interventions, community awareness and media reporting. The department, through projects such as Mindframe, LIFE Communications and Responsibility, works with media and other sectors to engage them in improving approaches to public discussion of mental illness and suicide.

As a result of this engagement and the guidelines developed voluntarily with the media sector, Australia has seen significant improvements in both the quality of media reporting in these areas and the volume of publicly reported suicide cases. For example, recent research has shown that, between 2000-01 and 2006-07, there was a twofold increase in the number of media reports about suicide. Importantly, the study found that the quality of those reports also improved greatly, with significant reductions in the use of inappropriate language, details of method and images of the location or the body of the deceased and significant improvements in the provision of help-seeking information. This is in contrast to comments made by members of the National Media and Mental Health Group that, prior to these initiatives, media rarely reported suicide for fear of causing further harm. What this indicates is that, whilst it is important to recognise and discuss the important problem that is suicide in Australia, it is also important to do so in the way that is most constructive and does the least to increase risk to vulnerable members of the community.

Finally, to close with a quick summation of future challenges that we see from the department’s perspective, of course there remains much more work to be done to further reduce the burden of suicide for individuals and the community. While we anticipate the development, with states and territories, of a national suicide prevention framework under the *Fourth national mental health plan*—as well as the next planned evaluation of the strategy, which will be incredibly helpful—there are some areas we already know need to improve. Suicide rates among Aboriginal people and Torres Strait Islanders remain an area of great concern to all governments and the community. Improving the capacity of Indigenous communities to develop holistic approaches to suicide prevention that recognise the complex factors that contribute to high rates of suicide is a key priority. Efforts to also improve the understanding of suicide for non-clinical professionals who work with people at higher risk of suicide also remain a challenge. A range of sectors, such as emergency services and welfare agencies, need to be able to build suicide prevention capacity into their regular work if attempts to increase front-line capacity to engage with suicidal people are to be effective.

Coordination of suicide prevention activity between the Australian government and the state and territory governments needs to be robust and meaningful if investment is to be optimised, duplication eliminated and service gaps identified and addressed—and, as I said, the alignment of suicide prevention activities under the *Fourth national mental health plan* is important and will require ongoing effort from all parties.

Finally, we always need to know more. For the first time, the National Suicide Prevention Strategy has invested in specific infrastructure to help us to understand the evidence from Australia and overseas, and the Centre of Excellence in Suicide Prevention has been funded since 2008 to do that work. It is something that we draw on constantly to inform our advice to government.

CHAIR—Thank you.

Senator MOORE—Both agencies provided a submission, but I will concentrate on Health and Ageing’s to start with. At the back of the submission you have put a detailed table of all programs that have been funded, and I would very much like to have more detail on that list. I have never seen it before. This committee has had a long-term interest in this area and it came as a bit of a surprise to us that we had never had this information prior to your submission. That apart, I would very much like to know, with this particular document, the terms of the funding. It does not say when, for how much and for what period they were funded. In fact, when you read the whole thing, you do not know whether things have concluded or not; I think a couple have concluded, but you would not know until you read all the detail. I would like to know the evaluation strategies that have been put in place and also whether they are public. That might then lead to some further questions, because as it is, while it is extraordinarily interesting to see how many things have been funded over that time, it provides no real help to us in finding out what they have done and what decisions have been made subsequent to what I think in a number of instances are completed programs.

Ms Harman—Senator, I can clarify a couple of those things. These are all projects that are currently under contract with the Commonwealth.

Senator MOORE—You cannot tell that, Ms Harman, from reading the document. That is the issue I have. With at least a couple of them in the main bit, it refers to data from 2007 and it does not tell you that it is still happening. It certainly does not tell you, with the exception of four, what evaluation strategies are or were in place.

Ms Harman—We can talk a little bit about that. We are referring to appendix D, aren't we?

Senator MOORE—We are referring to appendix A, 'Summary of key Department of Health and Ageing programs that support suicide prevention outcomes through social inclusion and improved access to mental health and general health services'.

CHAIR—It is page 347 in our briefing notes and page 80 in your submission.

Ms Krestensen—It might just help to clarify that that is a list of broader programs, within which the suicide prevention program nested, which also had relevance to suicide prevention. They are not specific suicide prevention programs; it is a broader range of mental health or related programs which are very much linked to efforts to support vulnerable people who might be at risk of suicide—Indigenous programs, drug and alcohol programs and other related programs being managed in other parts of our portfolio. But I take your point; it is very hard to understand whether they are current and so forth.

Senator MOORE—My point is that I want to have the information I asked for—what the terms of the funding were, whether the programs are completed and what the evaluation processes are in them. Then we might be able to ask questions about them. As it is, I could take up the rest of the month sitting here and going through each one—program 1, program 2—to find out exactly what is going on.

I want to ask specifically about ATAPS before we go any further, because ATAPS has been mentioned consistently through this document. One of the key points that Professor Hickie raised was about the link between people's hospitalisation and what happens afterwards, and it seems to me from reading this stuff that, really, ATAPS is the most focused of the programs on that particular issue. I just want to clarify where that is at, because I know that some were extended from January 10. There was a media release that said some had been extended and there was going to be an evaluation of the ATAPS focus on suicide and the demonstration programs by March 2010. Is that right?

Ms Harman—Under the ATAPS program, there is a pilot underway that gives funding through ATAPS to 18 divisions of general practice currently around the country.

Senator MOORE—Yes, and that is cited extensively in your submission.

Ms Harman—Exactly. That has been a highly successful project that basically links people who have presented either through their GP or to an emergency department, to broader support post discharge. As I say, it has been very successful and sets a good benchmark for us, moving forward.

Senator BOYCE—How has it been successful? How do we know?

Ms Harman—Feedback from providers and feedback from divisions. The ATAPS program itself is currently undergoing a review.

Senator MOORE—By whom, Ms Harman?

Ms Harman—That has been an iterative review over the last two years. A report is currently being finalised. It has gone out to the steering group for comment and will shortly be finalised to be provided to the minister.

Senator MOORE—And has that been an independent review by an outside consultancy?

Ms Krestensen—No, it is an internal review process. It is basically an iterative process.

Senator MOORE—Okay. So it has not been externally independently reviewed.

Ms Krestensen—No, there is an evaluation of ATAPS, which is quite a separate thing, which is undertaken on a regular basis by the University of Melbourne. On a yearly basis they review uptake and review the nature of the referrals to ATAPS, and that is the evaluation of the ATAPS program. This has been more of a policy review process to look at the extent to which ATAPS has been genuinely complementing Medicare services. That is what this one is about.

Senator MOORE—That is the wider ATAPS program, isn’t it?

Ms Krestensen—The wider ATAPS program.

Senator MOORE—We have followed that up quite closely, but the suicide demonstration program is what at least I think our question is about.

Ms Krestensen—That is also being evaluated by the University of Melbourne as part of their evaluation of ATAPS.

Senator MOORE—As a subset of the evaluation?

Ms Krestensen—That is right. Data is being collected on that. If I could add to that: we are still reviewing the input from that data because it is a relatively new program. It has been going for 18 months so far. I think it is fair to say that it was very slow to get going in the first instance because it involved changes to referral pathways, changes to the way in which divisions, GPs and allied health services related to accident and emergency services and state health services. We planned the location, the shape and the parameters of this program in consultation with state health departments, and we have been seeking their help in the development of referral protocols as we go along. It seems from what we have seen anecdotally that the uptake has increased a lot recently. In the early days there were very few referrals in some areas. I can speak of one division that I spoke to recently, which is Sunshine division in Queensland. That has had a very good uptake.

Senator MOORE—The Sunshine Coast, Ms Krestensen?

Ms Krestensen—The Sunshine Coast division; that is right. They had a very good uptake in the recent period of this project once they got the referral protocols in place with the state health authority. It is too early for us to give any more comprehensive information about the success or otherwise of the program, other than that it has been, as Ms Harman said, very well received by consumers and by service providers.

Senator MOORE—So what happens by March 2010?

Ms Krestensen—In March 2010, we are hoping to be in a position to, I guess, have a sense of where we go next with this particular program.

Senator MOORE—Which is now.

Ms Krestensen—It is the beginning of March. I guess by the end of March we are hoping to be in a position to know where to go next with this. The early indications are that a trial of this nature needs a longer period of time to run, but we just really have to review that in the broader context of the ATAPS program.

Senator MOORE—Will the evaluation report be released?

Ms Krestensen—I do not know but I see no reason that it should not be. Every other evaluation report from the University of Melbourne about ATAPS has been made public, so I would imagine that this one would be as well.

Senator MOORE—Thank you. On the COAG process that was talked about at length—about trying to coordinate services between state and federal governments in line with the mental health process—we have had considerable submission evidence and also the evidence today. Core issues that have been common, and there has been a lot that has been common, have been the lack of coordination of services. Certainly one of my understandings of the original COAG document was that one of the key programs was going to be coordination of services across the country. I still want to find out who is responsible for coordinating and where that is within the responsibilities within government and also within departments.

Ms Krestensen—The care coordination initiative that was part of the COAG plan in 2006 was, as you said, something for which joint responsibility was taken through the COAG plan, and the COAG groups that were set up in each state and territory were responsible for coming up in each state with their own approach to care coordination. There was a very strong emphasis on FaHCSIA’s PHaMs service and on other care coordination services, and there was a very strong emphasis on targeting people with severe and persistent mental illness through that care coordination. There was an acknowledgement across the COAG plan—and there have been acknowledgements since—that we needed to integrate our mental health services and suicide prevention activities generally, but the specific care coordination initiative that was part of that COAG plan did target people with severe and persistent mental illness, not the broader population, so efforts that were developed in each state and territory were specifically looking at ways of drawing together PHaMs and day-to-day living programs with state funded services targeting that particular population group to make sure that there was a strong link between clinical and non-clinical services, community based services and inpatient services to ensure that people did not fall between the cracks. My colleague Ms Winkler might be able to speak more about her knowledge of those care coordination activities.

Ms Winkler—I can comment about the ongoing process of the rollout of the initiatives managed through FaHCSIA.

Senator BOYCE—Could we talk specifically about suicide rather than the very broad view?

Ms Winkler—I can only talk more broadly about our mental health initiatives and those that are targeting people with severe mental illness. There was significant consultation with the states and territories about where services should be located and what other support service network might already exist from a state perspective as well as from a Commonwealth perspective in implementing those services. We had some other streams of service delivery, and obviously there is a cohort of the population who access all of those services who may or may not be exposed to suicide at some point in their life.

Senator MOORE—It was certainly my understanding when I visited fan sites that one of their aims was to ensure that they had a knowledge of what services for people with mental illness were available in their coverage areas so that they would be able to refer people who were affected.

Ms Winkler—A primary role of those services is to link those people more effectively back into the community and, hopefully, reduce over time the amount of time that they might need in hospital readmission or other things that might occur for them. We have undertaken an evaluation which we are expecting to go to the minister this month. The early feedback from that, particularly from the consumer and carer perspective, has been that for a number of those consumers it has had a significant impact on their connectedness back into community and their ability to participate in ways that they might not have participated previously.

Senator MOORE—Talking this morning with Suicide Prevention Australia and Lifeline, one of their major issues is that no-one seems to know exactly what services are available for suicide prevention, awareness and intervention in the country. There does not seem to be a coordinated model where all the work is listed that has been funded by the federal government and by state governments so that everyone knows exactly what is going on and who is doing what and so that people can share knowledge and best practice. Certainly my understanding of the COAG process is that, whilst the actual action plan went into quite specific areas such as you have described, there was an overriding preamble that talked about coordination and best practice in our country. I have not been able to pull that up. I have been trying to. But definitely the words ‘coordination’ and ‘best practice’ were in there. We are trying to find out who is responsible for having that kind of list of available services across the country and coordinating them so that they are not duplicating services or competing or not sharing the knowledge they have. Is that something that should be expected by anyone in the system?

Ms Krestensen—I can try to answer that. I think it is a fair concern. Certainly when we had our evaluation, back in 2005, of the suicide prevention program there was a very strong emphasis on getting better at communicating. That is why we have set up the LIFE project, currently funded through the CSS in Melbourne. It is supposed to be a hub of broad, generic information but also provide updates on where to get services and from whom. That is our central communication hub in terms of Commonwealth activities.

Senator MOORE—Are we talking with the CSS in Melbourne on Thursday? I am just checking. So the expectation of the department is that the CSS that has been set up in Melbourne provides that kind of hub for information?

Ms Krestensen—At a very high level, I guess it should have very clear generic information about what we in particular are doing. But it is also an opportunity for other governments to convey and promote their activities. Every department and every government has its own activity or way of promoting service delivery, and triage services like call centre networks and so forth are also a very big source of referring people to where they are needed. We identified some years ago the need to have a central hub for information, and that is what the LIFE project through CSS is intended to be. We are still enhancing that; we are still getting it right. But that is a place where people can put information about what they do, and it is a place where we can make generic information available on things like ATAPS referral pathways.

Senator MOORE—How is the role of the CSS hub being promoted to the whole network across the country?

Ms Krestensen—That is a fair question. I guess we have been funding them to promote themselves. They have been using conferences and networking. They have certainly been using the sector to get information out about themselves. State governments have been liaising a lot with the CSS LIFE project and promoting the LIFE framework through the project. They have become very familiar with it. So I guess in a sense we have funded them to self-promote.

Senator MOORE—How long have they been funded?

Ms Krestensen—They have been funded since 2008, and their funding runs out in June this year. We have made it public that we will be going to tender for the next phase of that project. We propose to continue a communications project and we will be going to tender to find an organisation to host that project beyond June this year.

Senator MOORE—Is that on the premise that CSS do not want to do it, or do they have to compete again in 2010?

Ms Krestensen—On the premise of good practice. Big projects which are originally subject to a procurement process do generally go to a further procurement process when a particular period of time has lapsed.

Senator MOORE—Two years.

Ms Krestensen—I think it is coming up to three years. I beg your pardon, I think it was in 2007 that they were originally funded.

Senator MOORE—I do not have that detail. Can we get that date confirmed. If it is as well known as it ought to be—after two years, 2½ years or whatever time it has been there—it seems interesting that the previous witnesses have not referred to this particular process. We did not hear of that program from witnesses earlier today, and one of their common themes was about the coordination of services and knowledge hubs, so that is interesting in itself.

Ms Krestensen—I hope I have not overstated the capacity of that central hub to provide, for example, information about locally based services. I do not think they could do that. Its function is not that of a service directory, but it is a hub of information about suicide prevention programs, state government programs. It is a vehicle through which we could provide a conduit on a whole range of things at a higher level.

CHAIR—Who uses it?

Ms Krestensen—It has had lots of hits on its website. I will see if my colleagues have any breakdown of the users of the website and the service.

CHAIR—From the quizzical looks of the audience—

Senator MOORE—which cannot be shown in *Hansard*—

CHAIR—I am getting the impression that they are not that aware of it.

Ms Krestensen—That project is currently the subject of an evaluation.

Senator MOORE—When is that evaluation due?

Ms Krestensen—The evaluation of the LIFE project is due in March and the evaluation of the CSS is due towards the end of June this year.

Senator MOORE—Who is doing the evaluation?

Ms Krestensen—We will find that out and let the committee know through the secretariat.

Senator MOORE—Can we also get the skeleton of the process—are they actually talking to the people they think might be using the hub to find out whether it is working? I expect that they would be, but I would like to have that confirmed.

Ms Krestensen—These are all very reasonable questions to ask. It was the first time we tried this experiment with a central communication project and we are looking to go through a continual improvement process. So if is not reaching the people we should be reaching, we do really need to look at that.

Senator ADAMS—I would like to ask you about the National Suicide Bereavement Strategy 2006. It has come up in evidence today that this project has not seen the light of day as far as the public are concerned. Why has it not been released, and when might it be released?

Ms Krestensen—This was one of a series of resources that was developed at that time. This issue has been raised with us by members of ASPAC and we are looking into it. But I suppose it was one of a number of resources developed. I believe other resources developed for that project have been made available. That particular one was called ‘a national suicide prevention bereavement strategy’. One bit of information that we do have available to us is that it was apparently developed without input from states and territories—

CHAIR—Did you say ‘without’?

Ms Krestensen—Without input from states and territories. That seems to be one of the reasons that there is a little hesitation about finalising and reviewing it. But we are looking into this. It was a 2005-06 document, and I guess there is a historical issue about digging it out and finding out if it is still up to date and whether it has relevance. But I think anything which is called ‘a national suicide bereavement strategy’ would need to be something that we would consult with our state and territory colleagues about before finalising it and making it available.

Senator ADAMS—It seems a long time. It has obviously been buried. I would think the people who did it would have talked about a lot of very practical issues that are still relevant today. I would be very interested in it. Could you take that on notice and let the committee know what the status of it is?

Ms Krestensen—Certainly.

CHAIR—In fact, could I go further and ask why there was no consultation on it with the states and territories. If the Commonwealth has done this, stakeholders have been asking for it—

Senator ADAMS—It is national.

CHAIR—and it is national, why wasn’t there consultation with the states and territories and why hasn’t that occurred over the last four-five years?

Ms Krestensen—I guess because we have been talking to the states and territories about bereavement projects in more recent terms, in terms of the projects that we are providing through StandBy and ARBOR in WA. In various states and territories, we are running bereavement support projects which provide urgent assistance to families bereaved by suicide. Our focus in terms of bereavement and our discussions with the states and territories have been more about the practical hand-on sort of stuff about where to provide services and also to make sure that we do not duplicate their activities. So it has not been something which has been raised in that context.

CHAIR—Wouldn’t all those services be part of a strategy? Isn’t the idea of having a strategy so that you have a strategy for how you provide those services?

Ms Harman—We will have to go away and look at the historical context of the development of that strategy and what happened in terms of consultations with the states. We will certainly let the committee know through the secretariat.

Senator MOORE—It seems that the issue of bereavement issues for families has come up as a major issue in most of the consultations in which we have been involved and it is also in many of the submissions. Why in a context where people see that as a need in relation to issues of families, and certainly the SPA has raised it consistently through their work, there has not been more consideration since 2005, I think Senator Adams said.

Senator ADAMS—2006.

Senator MOORE—It is about 2005-06. We are interested to get some feedback on that to find out the reasons. Once again, it comes back to the idea of coordination across the country. We know people are offering these services. We read about some of them being funded and some that have not been funded. How is the service being offered strategically across the country is our concern. We will find out why the document has not been made public.

Ms Krestensen—I believe it was a very long document. And I think it has to be said—

Senator MOORE—There does not seem to be a prohibition on us getting documents that are long, Ms Krestensen.

Senator ADAMS—We are quite used to it.

Ms Krestensen—We have produced a few in our time, too, I have to say.

Ms Harman—Senator, just to pick up on that last point that you made about coordination. That is clearly an emerging theme and one that we are very aware of—

Senator MOORE—Sorry, I do not regularly jump in on people, but coordination an ‘emerging theme’?

Ms Harman—I meant today.

Senator MOORE—Certainly, this issue of coordination has been a demand from the industry and from the community for many years.

Ms Harman—I apologise.

Senator MOORE—I do apologise if you said that it was just emerging today.

Ms Harman—I did not make myself clear, I apologise. This is something that we are very conscious of. It has come out very clearly in the fourth plan deliberations and consultations. It is a specified action in that plan that we actually do need to work better with our state and territory colleagues. We have got a commitment there through the fourth plan to develop a national suicide prevention framework. The other thing that will be important in this context—just drawing the link between mental illness and suicide—is the commitment through the fourth plan as well as the development of a national service planning framework for mental health services, which again will described in detail the levels of services that consumers can come to expect and which will set some sort of targets around. So there are two key national projects that we are already deciding to work on with states and territories that I think will have a big impact on improving the coordination and definitely the communications between us and the states and territories.

Ms Krestensen—Can I just add to my answer as I just found the right bit of paper in my briefcase. In terms of that bereavement strategy, elements of that strategy were picked up because it was a very long document. I am advised that that material was put into what was called a ‘revised bereavement pack’ which was finalised in consultation with states and territories and has been made publicly available. It is on the Living is for Everyone website and it is also available through the department's publication area. The process was that a broader document, which was called a draft bereavement strategy, was developed. Elements of that were incorporated into a practical bereavement pack, which was finalised with states and territories, and that was the document that was made available.

Senator MOORE—Made available when?

Ms Krestensen—It was made available on the website and I understand it was several years ago that it was made available. The bereavement pack was not something that was finalised in the last year or so. It has been made available in the last few months and that pack has incorporated elements of the strategy.

Senator MOORE—I did not understand that time sequence. The original report was 2005-06. Elements of that report have been taken out and then negotiated with states and territories, which is fine. When was it actually made available for people to have a look at?

Ms Krestensen—The bereavement pack was finalised several months ago and I understand it is because some of our stakeholders identified the need to finalise it, which was why we picked it up and pursued it, and that is the document that has been finalised.

Senator MOORE—I do not want to be picky, but when was it made public? We have 2005-06 and now we are in 2010. When was the pack available on the website for people to use as an endorsed product?

Ms Harman—Senator, I have just been advised that it was within the last month.

Senator MOORE—Okay. I do not feel too guilty then that I was not aware that it was out there.

Senator ADAMS—I am just doing my maths too on how long it takes to get any progress. This morning we had Inspire speaking about their Reach Out dotcom website, and we asked about MindMatters and whether there was a link from MindMatters to Reach Out. They said that in some states there was and in others there was not. Are you aware of that? You must be aware of the website because you partially fund it. Some states have a link and others do not. It seems to be a very vital component of the website and I would think there would be a tie-up with MindMatters.

Ms Krestensen—We certainly encourage our projects to promote each other, particularly in the youth space we encourage the MindMatters program, headspace and Inspire to work very collaboratively together and I guess cross-promote each others activities. I would be very surprised if there were not links to the Inspire website on the MindMatters website and I am pretty confident there are. I am a bit surprised to hear that. Is it about the state education system not picking it up, Senator?

Senator ADAMS—The comment was made that some states have and others have not.

Ms Krestensen—That is probably where the state education sector has picked up issues around Inspire on its own website. We fund MindMatters as a national project.

Senator ADAMS—I realise that, which is why I was asking you the question because you are the funders of it, and I wondered if there was any direction that these links should be made?

Ms Harman—We will follow that up, Senator.

Ms Krestensen—We do contractually require our organisations to work together because we think it is very, very important, particularly in spaces like youth that we have organisations that work with other organisations we fund.

Senator ADAMS—You will get back to us on that?

Ms Harman—Yes.

Senator ADAMS—Earlier on Suicide Prevention Australia made a comment that each year $17.5 billion—which is their account—is what suicide is costing. That is with people that do suicide and all the other issues that go with it. So could you comment on that? It is an awful lot of money, even as a ballpark figure, and I just wonder if you realise just how serious this is in terms of the effects it has—and this is work that that organisation has done independently.

Ms Harman—It is fair to say that there is no accurate data on the economic cost of suicide in Australia, and I think that is generally acknowledged. We are aware of that figure that has come through the joint submission from the various sector organisations. We do not have the detailed modelling behind how that figure was arrived at, so I am unfortunately unable to comment on whether I believe that is in the ballpark. I would need to understand how that figure was reached in order to do that. I think what we can do at the moment is obviously understand the burden of disease that suicide has in terms of the impact on the community. As I understand it, the burden of disease correlates quite strongly with the burden of disease for, for example, breast cancer and road traffic accidents. That is a good indicator of the level of impact—

Senator BOYCE—And burden of disease is the cost to the system?

Prof. Bishop—The burden of disease usually relates to the associated impact—lives lost and disabilities incurred together. I think that, the way these things are calculated, we do need to see the modelling because, as you know, while it is only 1.4 per cent of deaths, it is exaggerated each time because of the fact that it is often younger people—there is a much higher incidence of death in younger people—and they have a much longer productive life that an older person who might contract colon cancer. The volume is greater. So we would like to see the modelling behind each particular estimate. It will be high because of the longer time associated with younger people who have lost their productive lives. But there are a lot of assumptions in some of those modellings. We have all seen the modelling from Access Economics and others in relation to these types of illnesses, and they need to be challenged and understood and agreed whether these assumptions have some range to them or whether they can be accepted as they are.

Senator BOYCE—So what is your current assessment of the burden of disease, the costs?

Ms Krestensen—The AIHW’s burden of disease studies have suggested that suicide is responsible for just over two per cent of the burden of disease, and that is, as Ms Harman said, comparable to breast cancer and also to road traffic accidents. So, of the total burden of disease, suicide comprises 2.2 per cent. That is the figure that we have.

Senator BOYCE—What is that in dollars, please?

Ms Krestensen—What is that in dollars?

Senator BOYCE—Yes.

Ms Krestensen—I cannot quantify that in dollars. That is the percentage of the burden of disease, as opposed to a dollar figure.

Senator ADAMS—Hopefully, we will see you again towards the end of this inquiry, so would you be able to look at that issue and come back to us then with some modelling as to the actual cost.

Ms Krestensen—Senator, we did look at that particular term of reference and we would have loved to have been able to definitively answer it. It is very, very hard to quantify the social impact of suicide. We are pleased that there are people attempting to do so, but we did not have the information available to us to be able to do that. We did look, we did check and we found that we did not have that information available to us.

Senator ADAMS—Chair, when are we due to report?

CHAIR—June.

Senator ADAMS—So is there any chance that you might be able to give us a better answer than that by June?

Ms Krestensen—That is a fair question, Senator. We will see what we can do in terms of drawing together available information, but I did not want to raise an expectation that we would be able to say, ‘The answer is,’ and give a particular number. We will certainly draw upon the available information.

Senator ADAMS—We are very interested in it. It is just that many people have come up with some sort of modelling, so we just wanted to know where you sit as far as that ballpark figure goes. Thank you.

Senator BOYCE—Can I just follow up on that. Has the department looked at how to go about costing suicide and assessing the various costing methodologies?

Ms Krestensen—I will just say what I probably said very clumsily before: we did look seriously at that term of reference and looked to see if there was available, reliable information on costs that we could draw upon, and there was not, as far as we could see, not from Australia or from overseas. And I think, just from my brief reading of the submissions which attempted to estimate this, they are just estimating rather than drawing upon existing databases and information. So we did look for information we could draw on here or overseas; we could not readily find it but we will have another look to see what we can find.

Senator BOYCE—I think there were some suggestions that some of the Canadian and Norwegian models were perhaps useful, but many of the submissions would say that in Australian terms they have not got the data to do it. Given what has been said over and over about how we simply do not have sufficient statistics around suicide, I asked some earlier submitters whether they agreed with the view that the suicide rate has fallen. Do you believe that the figure that you have—is it 1,881?—is an accurate figure and reflects an accurate decrease in suicide in Australia?

Ms Harman—That is obviously the official data released by the ABS. I think we all agree that that figure is under-reported and that that is due to a number of factors. There is general acceptance, though, that there has been a general or steady decline in the suicide rate in Australia over the last 10 years, but with a disproportionate effect. That impact has not happened for those groups most at risk. The short answer is that we believe the suicide rate has declined over that 10-year period, we know that there is under-reporting in suicide data and we are looking forward with great interest to the next cause of death data that is coming out in March.

Prof. Bishop—There is a systematic error in the way that it has been reported. Often a coroner will decide that it is suicide after the reporting period in which the death occurred. That is a systematic error that occurs throughout and it is one of the issues that the ABS will be addressing. If you say that one of the other systemic errors is under-reporting because coroners are unwilling to make that finding, I would think that more enlightened views about mental health and suicide over the years would tend to produce more reporting rather than less. So there are a couple of systemic errors you can discuss, but for other factors we think the data may be inaccurate in an ad hoc way which really needs to be tightened up. It is very hard to predict but, taking those into account, the degree of reduction is quite large. Therefore, we would be able to say fairly reasonably that there probably has been some reduction, although we understand that the data is not accurate in each of the components.

Senator BOYCE—That raises some evidence given earlier, which was that the Victorian coroner has stopped reporting deaths to the Commonwealth. Are you aware of this?

Prof. Bishop—Yes, that is something that obviously the federal agencies are taking up. I know that the Australian Institute of Health and Welfare will be having discussions with the Victorian government.

Senator BOYCE—Do you know how long this has been going on?

Prof. Bishop—I do not know. I think it is more to do with their own particular requirements. It has been such that the Victorians have always reported deaths up until relatively recently. This is something on which the Victorian registrar of deaths has obviously taking a particular view, and there are ongoing discussions to try to make sure that we have a very good national view of deaths. It is important for so many things.

Senator BOYCE—Yes, it seems a bit hard to develop national standards if we do not have Victoria in there or a national overview.

CHAIR—Is that the only state at the moment that is not reporting?

Prof. Bishop—As far as I am aware.

CHAIR—So it is all of Australia except Victoria.

Senator BOYCE—Ms Winkler, just getting back to the PHaMs program, within this evaluation will you be evaluating the level of unmet need for that program?

Ms Winkler—Not specifically. We have not addressed that. Basically we have been looking at all of the streams that we have funded through the COAG initiatives—PHaMs, our respite streams and some community based projects. We have data available about the clients who have been in the system. Some have subsequently moved out of the system. I would have to check—

Senator BOYCE—Have they chosen to move out of the system or have they left because there was not any money there?

Ms Winkler—Because we have now been operating over a number of years and it was always perceived that clients would use these services not necessarily just for a short period but over an extended period of time, some of those clients will have exited the program because at a given point in time their needs had been met or their circumstances had changed. Some will have exited the program because they have moved to other areas.

Senator BOYCE—But that is not unmet need, is it?

Ms Winkler—No. We always knew when we set up this program that the funding that was available would service probably up to one fifth of the population that was there in the community. So we know, even working collaboratively with our state colleagues to try and locate the services in the most appropriate locations, that there is still quite a significant amount of unmet need because of the numbers of people that can actually access the service.

Senator BOYCE—So you consider that it still meets the needs of one fifth? Is that your view?

Ms Winkler—Our view would be that there has not been any broader expansion of the program to enable it to meet a larger number of that population.

Senator MOORE—Do you keep data about whether any of the clients have suicided?

Ms Winkler—I would have to go back and check the detail. There is certainly some level of information about clients and their reasons for exiting the program.

Senator MOORE—If that data is kept, it would be useful if we could have a look at it and see what the numbers are.

Senator BOYCE—Yes, that would be good.

CHAIR—When Senator Boyce is finished, I would like to go to that issue. I think at least some of you were in the room when we were talking to the Brain and Mind Research Institute and also the Mental Health Council earlier about the data and following up support services, care providers and the data that is kept around contact with people.

Ms Winkler—When you say the data that is kept around the contact—

CHAIR—The fact that the data is not collected. There is not ongoing contact, support or provision of care necessarily for those that have—

Ms Winkler—Once they have exited our services.

CHAIR—An acute care episode.

Senator MOORE—Except for the 83 in New South Wales—that is being piloted.

Senator BOYCE—Do they link with any other service after that and then what is their experience in there?

CHAIR—The point was made about how we know how many people are alive three or six months after coming out of an acute care episode for example.

Prof. Bishop—Can I just make one small comment about that. I agree with what you are saying about the need for data. One of the difficulties is linking up data sets that are in different jurisdictions and are for different purposes. This is just a widespread issue for all of our health services. As you know, the NCRIS model for data linkage was one of the large projects that came forward to try to deal with this. Nevertheless, the data linkage between various ways that data is collected is an ongoing problem. I think everyone will attempt to get the data in the way that you wish to have it. It is quite a difficult exercise to make sure that it can be done exactly as we would all want it for this particular purpose.

CHAIR—I think the point here, if I understand it correctly, is not just about linking it up; it is about collecting it in the first place. That issue has been raised a number of times but, from evidence that we have received today, that information just is not being collected. It seems to me to be one of the most obvious things if you are dealing with mental health and people who have attempted suicide to provide that ongoing care. They should automatically, I would have thought, be identified as a high-risk group along with the other groups we already know are high-risk groups. I would have thought those people would be a high-risk group that should be followed up. We have been told 65,000 people attempt suicide each year and there is no regular follow up for those people. Obviously some get into support services, but it sounds like there is a high-number of people who do not have that follow up care.

Prof. Bishop—We can certainly give you a more definitive answer about what we do in relation to that, but I will make one point: the follow-up is obviously fragmented as well and that is part of the difficulty in getting the data.

CHAIR—That is the point, is it not?

Prof. Bishop—Yes.

Senator MOORE—Can we follow up on the Community Connections project in New South Wales which seems to me to be the only one listed in these funded programs that goes close to the kinds of issues that Senator Siewert is referring to. It is on page 109 and says that between June 2007 and May 2009 that particular number of consumers were followed up. Is that program still running?

Ms Krestensen—It is. All the projects in appendix D are currently funded. They are funded to this financial year onwards. That project is one that has just had its funding extended to June 2011.

Senator MOORE—That one seems to be getting close to the kinds of issues people have raised about follow-up of people after discharge. It is a very small project. Could the knowledge gained from that be extended? We cannot tell that from the box of information on that page.

Ms Krestensen—It is a very innovative project. It provides peer support from mental health consumers, as consumer to consumer support. It has been very well received in the area where it is running around Campbelltown and Liverpool. The model from this project is actually a model that we have been in informal discussions with our state and territory colleagues about. There is a lot of interest in this idea of peer support as a way of better supporting mental health interventions and suicide prevention interventions. It is under discussion, but we do not yet have anything to offer in terms of how we could take it forward. But it is the sort of model where we could do that, like the CSS project—use the CSS project to disseminate information and promote this as an effective model. I have not yet read the evaluation—

Senator MOORE—Is this information about the way this program is operating on the CSS hub in Melbourne?

Ms Krestensen—If it is not it should be. I have not actually read the evaluation of this project. I have heard in discussions with state health that they quite liked it in New South Wales and it has certainly been very well received when it was continued. It was given a lot of raps by the people who had anything to do with it. The reports that have been received by our state office that has been accessing it have suggested it is going extremely well. But it is very hard to link it back in terms of evaluative outcomes.

Senator MOORE—How much money has it got?

Ms Krestensen—I would have to take that on notice.

Senator MOORE—Appendix D does not have any dollar value.

Ms Krestensen—We have that here. $253,000 in 2009-10 and $263,000 in 2010-11.

Senator MOORE—It has been going since 2007?

Ms Krestensen—Since 2006.

Senator MOORE—It has been around the $250,000 figure for all those years?

Ms Krestensen—Given that we have just continued all the projects at their current level, I would suspect that that would be the case, but we do not have those figures here at the moment.

Senator BOYCE—Whilst reading your submission and looking through the appendices, one gets the impression that, in practical terms, suicide is a subset of mental health for the Department of Health and Ageing. Is that an accurate assessment?

Ms Krestensen—I would not put it quite in those terms. We were trying to say that our suicide prevention efforts are certainly manifest in our broader investment in mental health. I think the people this morning were very clear about the fact that not everybody who attempts suicide has a mental illness, so you cannot presume that it is directly correlated with the same group. We see that our efforts in suicide prevention are extended and that they have to leverage upon our broader mental health investment. Given that people who have a mental illness are eight times more likely to be suicidal, it would be irresponsible of us if we did not have a strong focus on embedding suicide prevention learnings and principles within mental health programs.

Senator BOYCE—We have had evidence today suggesting that, given the level of cost of suicide, whether it be in human life or in other terms, we should be treating it as distinctly and as well as we do road deaths and the like. Can that happen while it is seen within a framework of overall mental health, which, as we all know, is a very diverse and complex area, far more so even than suicide?

Ms Harman—Whilst Ms Krestensen was right in saying that our suicide prevention efforts nest within the broader mental health programs, but I think it is also right to say that there is a specific program, a whole section, within Colleen's branch that focuses on that.

Senator BOYCE—I realise that, and that is why I used the term, 'in practical terms it seems that suicide is seen as part of mental health.' Suicide strategies are seen as part of mental health strategies and not as a stand-alone focus for the department.

Ms Krestensen—I think it does have a stand-alone focus. I am sorry if I have led you into thinking otherwise.

Senator BOYCE—No, I do not think you have misled me.

Ms Harman—I think that is right. We do have a whole team that focuses on suicide prevention as their day job, so it is certainly not something that we bury within the broader mental health programs. It is also important that there are synergies between the two, that our staff who work on mental health more broadly talk to one another in terms of the suicide prevention work and that we work better with the state and territory colleagues on this, too.

Ms Krestensen—That is why we have to make sure we do not lose sight of the important investment in population health and universal approaches to suicide. Whilst we are very keen on targeting those most at risk of suicide, we also have to make sure that we invest in those population approaches that spread the net a bit more broadly, given that it is not always predictable who will suicide. As David Crosbie said this morning, and I think was very clear about it, we need to make sure that we act upstream and do not just wait until someone attempts to suicide. We have to intervene with broader population health approaches that build in protective factors like resilience, help-seeking and those sorts of issues, which would come under a broader population health approach.

CHAIR—That is, essentially, health promotion. What proportion of funds do you spend on that element of your strategy?

Ms Krestensen—We will dig that out and give it to you, Senator. It used to be a 60/40 per cent split.

Senator BOYCE—Between what?

Ms Krestensen—Sixty per cent was invested in local state projects that targeted high-risk groups and 40 per cent was kept to a national level—sorry, forgive me, I will start again. Sixty per cent was spent on the universal, national projects, which had a population health approach, and 40 per cent was spent on local projects, which had more of targeted approach. Those figures go back to pre 2006. Since then there has been a bit of a blurring in some of our national projects. The ATAPS fund that we have been talking about does have a targeted focus even though it is a national project, and some of the national approaches to bereavement that we have taken also have a targeted focus. Conversely, some of the local projects that we have funded over the last three years have a whole-of-population approach. For example, Indigenous projects such as the Koori one that we run at Shoalhaven has a whole-of-population approach in that it takes a school based approach to supporting the kids, rather than taking a very targeted intervention type of approach. So it is not as clear-cut as it was some years ago whereby it was national, population based and local, targeted based. We are doing a bit of both at each. We will certainly dig out the figures about the extent to which we are investing in universal and targeted approaches.

CHAIR—Thank you.

Senator BOYCE—Following on from that, how many of the evaluations we have been talking about for programs that are relevant to suicide would ask a question that would give us an answer that says, ‘This many lives have been saved for this length of time by this program’?

Ms Krestensen—That is a fair question to ask but it is one that we have had the advice of the suicide council on for some years. Suicide is a very tragic event but it is what they call a ‘rare low-incident event’ in statistical terms. It means that, if you take a very localised area and measure .the number of suicides in that area, one suicide can blow the data for years and years because it is such a small incident event.

There has been a suggestion by a range of people that you have to be very careful about taking short-term projects with small samples and trying to link them to suicides in the area because just one suicide can totally throw the data and suggest that a project is unsuccessful. Conversely, a project that might not be going well might be in an area where there is not a suicide. It is very difficult to link small targeted projects—

Senator BOYCE—I would not be suggesting it was the measure but one of the measures. Is it not used at all?

Ms Krestensen—For each of the projects that we fund we give a very detailed instruction guide on evaluation, and I am happy to make that available to the committee, which requires them basically to give us information about what they have done, for whom, at what cost and to what effect. If they have any available information that can link it to outcomes, they provide it to us. They do their very best to address the specific evaluation questions that we provide in that. It is like a template that we provide to every project to give us some data to help us, at the end of the day, draw some information together.

CHAIR—If you could provide us with that document that would be very much appreciated because I think this goes to the issue that we were talking about earlier rather than just measuring activity, how we are measuring outcomes.

Ms Krestensen—Absolutely. Graham Martin has done some very interesting work where he has taken lots of little projects like this and the data that they collect and put them into a meta-analysis and then you can actually draw out some information.

Senator BOYCE—You have done that.

Ms Krestensen—Graham Martin and one of his collaborating researchers in Queensland did that particular piece of research specifically looking at the Youth Suicide Prevention Strategy and suggested that there had been some improved outcomes from that particular investment. That looked at the long-term impact of that strategy. We will also provide that reference to you. I do not have it at my fingertips.

Senator BOYCE—It has not been looked at by the department in terms of perhaps a methodology that you might consider adopting or broadening?

Ms Krestensen—I think it is fair to say that our evaluation strategy, as Ms Harman said, is very much that we developed an evaluation framework back in 2006. From that we developed an evaluation protocol or template for each project and each project is providing what they can about their own evaluation. There will be a meta-evaluation in 2010-11 which draws together this information and I would hope draws together the expertise of people such as the Centre of Excellence in Suicide Prevention at Griffith University to make the most of the data that is available to us. Put together often you can get some very interesting information from these kinds of evaluations. That would be the plan that we have. You seem to understand the fact that you cannot look at a particular small project and either praise them or condemn them depending on the suicide rates in their area. That is the issue.

Senator BOYCE—However, we do need to try and work out—and the point has been made here—how you decide which are the good ones so that you can be pushing them as a best practice approach and which ones appear not to be doing anything. We would be interested in seeing that evaluation. Is the contract let for the meta- evaluation? Are the time lines set for that or is it on your list?

Ms Krestensen—It is on our list. I hope the time lines are a little bit better than they were with the bereavement project. We would be looking to have those undertaken in the next financial year, so we would be moving very soon to start the tender processes and so forth to take that forward. We have not yet let the tender, we have not advertised, we are still in the position of scoping that at the moment.

Senator BOYCE—I certainly imagine there would be a lot of interest in that from the evidence we have had to date. Thank you.

Senator MOORE—One thing we need to follow up, and we will not do that today because there is so much, is the Indigenous issues. I know that everyone has lots of questions about the whole area of Indigenous vulnerability and the work between FaHCSIA and health in that area. I have one question about the two advisory groups to the minister in that we have the advisory group on suicide and the advisory group on mental health. Is there any crossover between those two groups?

Ms Harman—Absolutely. There is a joint member, Dawn O’Neil from Lifeline, who has been anointed as the conduit between the two groups, so the information does exchange and that has been agreed by both groups.

Senator MOORE—Right. Then both those groups operate in a secure way, so their information goes directly to the minister?

Ms Harman—That is exactly right.

Senator MOORE—In terms of our ongoing issue about where suicide fits within the mental health program and how much of a priority it is, the two groups do have this crossover so they can actually feed each other.

Ms Harman—That is correct.

CHAIR—I have a couple of questions. We touched on unmet need earlier but we went on to talk about something else so I do not think we fully addressed it. It seems to me that we are not following up with people when they come out of hospital or emergency services. Late last year I was talking to Youth Focus—an organisation in WA that specifically works with young people; you are probably aware of them—and I found it disturbing when they said there are at least 250 contacts asking for help that they are unable to support. That is 250 kids who are not being supported, certainly by that service. Whether they are able to access another service I do not know. Do you have a handle on unmet need in terms of people who are actually approaching services? There is obviously the group that do not know where to go and are not seeking support. Do you have a way of measuring the number of people who seek support and are unable to get that support because of lack of resources?

Ms Krestensen—I guess the best resource we have is the recent survey of mental health and wellbeing, which showed that unmet need was a problem generally in the mental health system. I can only speak about the mental health system in that respect. It showed that only 35 per cent of people who had a diagnosed mental illness had access to services in that particular calendar year. I guess that shows that unmet need within the system is a significant problem. It is not clear from the information we have whether that is people not being able to access services or whether it is people not wanting to use services. I think the survey showed a great reluctance of some people with a mental illness to seek services. So it comes back to that issue about promoting help-seeking. I think there are two problems here. One is that there are obviously some people who, because of where they live or because of the availability of services, do not seem to be able to get the services they need. Another area of concern, particularly with young people, is help-seeking—ensuring that people are encouraged to go forward and seek support. In the suicide prevention world that is extraordinarily important.

CHAIR—You are right; those are the two issues, but when young people in particular work up the courage to actually seek help, to approach a service and to be told, ‘We cannot support you because we just have not got the resources,’ I would have thought that would have a very negative effect on people. It takes a lot, I should imagine, for people to work up the courage, particularly when they are young, to seek that support. Do we not really have a handle on that?

Ms Krestensen—I do not have any information on the number of people who would be doing that sort of thing. I have spoken to Youth Focus and they are certainly very aware of other services that are available in Perth, such as headspace services for young people and ATAPS services through divisions and, of course, better access services. I know the individuals involved; they are delightful people and I am sure that if they cannot provide the services they would be referring young people to where they might be able to get services.

CHAIR—Do we have an idea of how many young people are accessing ATAPS services?

Ms Krestensen—We do. I can get that information for the committee. I do not have that at my fingertips but we do have that.

CHAIR—That would be appreciated. I would be interested to know how many young people are actually accessing those services through their GP. One of the other issues that came up this morning was stigmatisation. There was a lot of comment this morning that there are not enough resources going into addressing issues around stigmatisation of mental health and particularly suicide. We were talking earlier about those being two separate issues. The comment was made that there has been some progress on stigmatisation around mental health. I am not saying it is fixed in mental health, but there has been some progress. But the feeling I got from our witnesses this morning was that stigmatisation around suicide is still lagging and there are not enough resources going into those programs and awareness of suicide. Have you got a comment on that? What is the department’s approach?

Ms Harman—The department’s approach currently through the suicide prevention program, the funding arm of the strategy, is to fund a number of local community projects. Part of their remit in a number of the cases is to include community awareness activities at a local level.

CHAIR—The comment was around national awareness policies.

Ms Harman—Yes, absolutely, through the strategy as well we have national issues like the Mindframe initiative. We all know the role that media can play in either presenting suicide in a positive and responsible way as opposed to doing damage. There is an example of the universal approach that we currently take. In terms of a discrete funding stream that we have for a national communications approach, we do not have such a bucket of money, so we use the strategy and the funds available through the ways that I have described.

CHAIR—Why isn’t there a bucket of money?

Ms Krestensen—There is funding for Mindframe initiative. We also invest in other universal measures. Even the MindMatters program has a very, very high emphasis on reducing stigma, help seeking, promoting help-seeking behaviour and encouraging students that, if they or someone that they know is suicidal, to seek help. So there is investment in a broad range of activities in that respect. We do have quite a broad range of things under way. We invest separately in beyondblue and in KidsMatter initiatives. I think there are a range of things going on but the broader approach to stigma is an issue that we are talking to states and territories about in the context of the *Fourth national mental health plan*.

CHAIR—Is it likely that, as a result of those discussions, there will be funding allocated for a national program?

Ms Harman—That is a decision for government.

CHAIR—Is it something that is on the table?

Ms Harman—I do not think I can comment on that at this point, Senator.

CHAIR—I want to go back to the issue of data collection. We know where we are up to with the ABS data coming out after 17 March, and I am hoping that we can talk to ABS after they have released the data; it would be easier to talk to them after rather than before. I want to go back to the issue around follow-up services and getting a handle on outcomes rather than measuring activity. This has been on the table for some time and we do not seem to be making much progress. What is the department’s approach and attitude to that? In other words, looking at follow-up, looking at outcomes and getting a handle on how successful our programs have actually been in the longer term.

Ms Krestensen—Our investment in the centre of excellence through Griffith University was really to get better information about some of these issues and to see what we can glean from the available information about things like follow-up services, what sorts of services should be available and what are available. In the broader data world through the fourth plan we are working with states and territories to develop a service planning framework, which would be looking at better ways of collecting data about a broad range of things pertaining to care pathways and services. That would have to be put into that pond which is going to be the big pond for developing data type activities. In terms of specific suicide prevention expertise, we have invested in the centre of excellence, which is very, very good at these kind of issues, to get advice on what data is available and what we can glean from available data resources, but in terms of enhancing our data collection and working with the states and territories to get better information about what care is provided to whom and where the gaps are, the service planning framework would be the big vehicle upon which we would be putting this sort of effort. There is an indicator in the fourth plan about suicides, so it is entirely relevant to that. That would be the direction we would be going.

CHAIR—From what I can understand it is not a question of collecting existing information; that information is not being collected. Is the project also talking about the requirements for collecting that information?

Ms Krestensen—The service planning framework project is basically sitting down with states and territories and working out what the key indicators in the plan were, how to better plan service delivery against those indicators in areas of the fourth plan and about working out to targets. Health ministers have been quite open in their comments about taking forward the fourth plan, that they will be setting targets around parts of the fourth plan and working out ways of collecting data to measure those targets and measure how care is being provided.

CHAIR—Is one of the targets: every person that leaves an emergency department as a result of a suicide attempt, anybody that needs acute care as a result of a suicide attempt, anybody that leaves any other service as a result of a suicide attempt, will have follow-up services and a care plan as they leave that service so that nobody leaves a service without having follow up and without having care. For example, in Narrogin an Aboriginal man was delivered home from Bunbury, left on his doorstep and nobody was told. This was after coming out of hospital. He was just left in Narrogin where we know there is a high suicide rate. No-one was told that he was coming home. There were no support services provided. There is a male social worker in town but there is no female social worker in town, et cetera. Is that part of the suicide plan so that we have wraparound services?

Ms Krestensen—What you are describing sounds like a breach of appropriate care.

CHAIR—It is not the only episode. That is one episode of a lot that I have heard of in Western Australia.

Ms Krestensen—Even if we have better data to collect and measure hopefully that will improve care provision. It is not going to stop, unfortunately, the inappropriate practices such as those you have described. One of the indicators in the fourth plan is around post discharge follow-up so I am very, very hopeful that there would be indicators and targets developed and pursued of measurements of what is happening specifically in those circumstances. I agree with you that we need to get better at ensuring there are very clear protocols and data importing to ensure this sort of thing does not happen.

CHAIR—The data reporting is very important but it is the step before that and making sure that everybody does it. Fair enough that you say that is outside normal procedure. As I said it is not the first time I have heard that and it is not the only one. There are regularly people being discharged from hospital that have no follow-up at all. No-one knows if they are going home to family et cetera. Is it part of the plan that everybody has that?

Ms Harman—There is an annex to the fourth plan where there are a whole range of indicators that all governments have signed up to developing. They are listed in detail and against technical notes as to whether or not that data is currently collected. There has been a commitment by all governments that if data is not currently collected then governments will work together to collect it. Targets will be set against each of those indicators. Priority area 3, which is Service access coordination and continuity of care, there is an indicator for readmission to hospital within 28 days of discharge and I understand that is a downstream indicator. Rates of readmission to community care is another one as are rates of post discharge into community care and average waiting times at emergency departments. There are a whole range of indicators that hopefully will work collectively to improve the gaps that we know exist currently in the system.

Senator MOORE—Is that for all mental health conditions?

Ms Harman—That is right. The fourth plan is for specialist mental health systems.

Senator MOORE—It is for anyone who has had an interaction with mental health services.

Ms Harman—With the acute care system with specialist mental health services run by states and territories or with primary care.

Senator MOORE—Ms Harman, can we all get a copy of your fourth national plan?

Ms Harman—Certainly.

CHAIR—Thank you very much.

Proceedings suspended from 3.38 am to 4.00 pm

MENDOZA, Adjunct Professor John Anthony, Private capacity

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Prof. Mendoza—I am here as director of Connetica Consulting and I was responsible for the preparation of submission No. 65 and also another submission which I pulled together on behalf of a task force. I cannot remember the number, but it essentially deals with the desired infrastructure for changing Australia's response to suicide prevention to date.

CHAIR—You are an old hand at this.

Prof. Mendoza—I am. I have sat before many Senate committees, mainly estimates, which are slightly more uncomfortable than today's hearing! Whenever Senator Faulkner walked into the room I trembled.

CHAIR—You will therefore be aware of parliamentary privilege and the protection of witnesses and evidence. We have the submissions that you just mentioned before us. I would like to invite you to make an opening statement, and then we will grill you, but maybe not as badly as in estimates.

Prof. Mendoza—I hope so. Thanks very much. I wish to begin with an opening statement and I thank you for the opportunity to do that. I firstly want to congratulate all of you as senators for establishing this inquiry. I believe that such an inquiry has the potential to change the lives of thousands of Australians, if not millions, in the future. I base that optimism on the fact that in my own career I have seen the impact of Senate inquiries such as the drugs in society inquiry led by the then senator Peter Baume, the drugs in sport inquiry led by then senator John Black and the mental health inquiry led by then senator Lyn Allison, all from different political sides in our democracy. All of those inquiries that I referred to have had a profound impact on the lives of many people and the respective fields that they dealt with and they have impacted on my own career. I was the head of the Australian Sports Drug Agency and deputy head for 10 years. I believe this inquiry has that same potential and I am grateful to all of you for establishing it.

I come here with some degree of expertise in suicide, mental health and health promotion. But I also come, as I am sure many people will come, with a lived experience, so to speak, as a carer. We have cases of suicide attempt in my family. I have a nephew who has survived several attempts at suicide since his East Timor posting and I have a father-in-law, a Borneo veteran, who since 1995 has dealt with suicide ideation and has attempted suicide on a number of occasions. In relation to my own mental health, I have had periods where suicide ideation has in fact been the prompt to seek help. Regarding Professor Hickie's comments earlier about the relationship between suicide prevention and early intervention in mental health, I can certainly testify from my own direct experiences to the nature of that relationship.

In this hearing and in my opening comments I want to begin by focusing on the personal, social and financial costs of suicide in Australia, something which we made a start on in submission 65, and I will provide the Senate inquiry with a further development of that issue in a paper which I will leave for you. I should also say that I am undertaking work on behalf of many of the organisations that funded those submissions that I prepared and doing further work on the issue of the economic cost of suicide in Australia, because I think it is very important that we establish the extent of this problem from an economic point of view as well as, obviously, the personal and social issues.

The second issue I will talk about is the inadequacy of the response to date, something which I am openly critical of because, from my own experience as a senior public servant, as a Commonwealth statutory officer, I believe that Commonwealth officers have a unique position to ensure that we get the strategic policy right in relation to very difficult issues that show no respect for borders and which, if we do not get right, do have a profound impact in their respective areas. The drugs in sport area is a good example. I was privileged as a Commonwealth officer to have the responsibility of tackling that problem not only in Australia but globally and, as a consequence of that, we have a far more level playing field in sport than we did 15 years ago. Finally, I will speak a little bit about the response that we do need.

I want to talk firstly about the personal, social and financial costs of suicide. I am going to emphasise the financial aspects of it because I know that today you will have heard more about the personal and social aspects from Lifeline and others. Suicide and suicidal behaviour, including self harm, bring with them massive human, social and economic impacts. Estimates indicate each suicide impacts directly on at least six other people. International studies are the source for this. A completed suicide has a multiplier effect, impacting the lives of any number of individuals from family to friends, colleagues, clinicians, first responders, coronial staff, volunteers from bereavement support organisations and other associates. To some extent all of those people suffer some impact from suicidal behaviour. For some there is an intense and ongoing impact. The economic costs are enormous, given that the greatest number of suicides and self-harm episodes occur before the age of 44 years in our population.

I had an interview last year with a senior manager of the QAS, the Queensland Ambulance Service, for a project I was undertaking for Suicide Prevention Australia in which I produced a number of interviews with senior managers in a number of organisations around Australia who had taken direct action to prevent the impact of suicide and suicidal behaviour on their staff. He told me of an incident in the southern suburbs of Brisbane where two staff, Queensland Ambulance Service officers, were deeply traumatised by an event. They took a young man in his early twenties to a hospital on the south side of Brisbane—I will not name that hospital because, although I have not inquired, there are probably some legal issues—where he was admitted through the emergency department. They went on and did the usual things they have to do on a Friday night in a metropolitan area and attended to other incidents. But two hours later they received a call from their operations command to attend to an incident on a railway line very close to that hospital. When they arrived they found dead the same man that they had taken to the hospital in a psychotic state. He had taken his life in front of a Brisbane suburban train. The impact on those two officers is that they have not worked since that date in 2008. Clearly their families and close friends would be deeply traumatised by that.

As someone with a bit of a railway heritage I take an interest in what goes on in railways, and every week in Queensland one person takes their life in front of a train. That means 50 or 60 drivers are deeply affected by this. This is something that is not in the public domain. It is rarely disclosed in the press. Many of those drivers never return to duties. The union that is concerned for their welfare, and Queensland Rail, I think do what they can in order to prepare their drivers in both resilience training and dealing with trauma, but nonetheless many of those folk are unable to return to work as a result of their experiences. These are just one or two minor examples of the impact on others as opposed to the impact obviously on the individual concerned and their immediate family. The ripple goes far beyond.

It has an economic impact. The estimates of the cost of suicide, both attempted and completed suicide, can be useful to us in two ways. Firstly, the estimates can give us some idea of the conditions and the populations in which the burden of disease is greatest. It can therefore give some guidance as to where our research should focus on developing new interventions to reduce it and give us the greatest potential gain. Secondly, the detailed estimates of cost components can provide useful input to cost-effective analysis of the proposed specific intervention and its subsequent evaluation. Sadly, we have never done a study of the cost of suicide in Australia. There have been some attempts overseas, and we have had private organisations such as SANE Australia fund detailed cost estimation exercises done by reputable national firms into the cost of bipolar and schizophrenia in the past two years.

As well as the cost to the individual, it is important to contextualise suicidal behaviour and appreciate the ripple effect it has caused in the lives of families, friends, colleagues and acquaintances. The research says that up to six people are affected. I think it is far more than that, from the sorts of experiences that I have relayed from my own family but also from those examples I just gave. Frank Campbell, who may have been mentioned to you in earlier hearings, in his seminal work on changing the legacy of suicide states that up to 28 relationships are impacted by one suicide. I think that is probably closer to the mark than six.

People will be impacted in various and many ways by a single suicide. The research has simply not been done to articulate the actual number of people impacted and all the breadth, depth and length of that impact. It is partly because, as Professor Hickie said earlier today, we simply are not counting the number of people who die as a result of suicide in Australia. We really have put far too little effort into getting a better handle on that.

If we compare this to road traffic deaths and we compare what we have done in this area, it is a rather stark contrast. We have had three decades in Australia of sustained investment and coordinated national policy and program action in relation to road trauma. We now have New South Wales, just a year or so ago, being amongst the best five jurisdictions in the world in terms of road deaths per 100,000 people. You would not think that, from looking at the newspapers; you would think that New South Wales was a very unsafe place to drive. But in fact it is one of the safest places in the world to drive. Victoria was in that same league a couple of years earlier but has dropped back into the second tier of best performers in recent years.

The annual economic cost of road accidents and road deaths in Australia has been calculated at $18 billion in 2005. Road injuries and deaths receive extraordinary scrutiny, analysis and timely reporting, and there is ease of access to the detailed information. Any one of us can go to the Bureau of Infrastructure, Transport and Regional Economics—you have got to keep track of their name so you can punch in the right name on the computer!—which has a database that is accessible to everyone in the community, with over 500 well-funded research, evaluation and monitoring reports that tell us the investment history and can give us a longitudinal picture of where we have come from since 1981, when the first study on the cost of road trauma was funded.

As a consequence of developing that understanding of the economic cost of road accidents as far back as 1981, we have got a sustained, well-funded, bipartisan road safety program within a robust policy framework. It has existed for a long time and it has continued to develop over that 30-year period. Furthermore, the savings made by those investments in road safety are presented to governments regularly to support ongoing targeted investments. That approach is a strategic, longitudinal, well-funded research program, with accessible data and timely reporting—I can look at the January road accident statistics for Australia right now, one month from the end of January. The contrast between that and what we see in suicide prevention could not be more stark.

We are now, I think, confident in saying that the death toll in Australia due to suicide each year is significantly, by several hundred, higher than the road toll. The road toll this financial year will be around 1,400 across Australia; the suicide total numbers are probably going to be in excess of 2,500 for the same period. There is now a very significant gap. As I said, the burden of that disease falls greatest in the age groups below 44.

There is the inadequacy of the response. Submission 65 and to a lesser extent the other submission that I referred to are highly critical of the stewardship of the federal Department of Health and Ageing in this area. There has been a failure of responsibility at the senior executive level. I said to you before that, as a senior Commonwealth officer, you have a great opportunity to effect national policy. You are simply not there as an empty vessel waiting to be told what to do by government. You have a role to inform government of what is possible, inform them of other approaches around the world and inform them of how we can do better with scarce resources. What are the best buys, indeed, is one of the key things that one needs to be able to advise government about.

I believe that for at least this decade, since 2000, we have not being seeing strategic policy advice coming through to governments about how to respond to the issue of suicide in Australia. I think we have fallen into a sense of complacency believing, and wanting to believe, that the suicide data was declining, and listening to some of the people who were sounding some warning bells about that data was not really taken up. As a Commonwealth officer you have to listen to both of those sorts of perspectives and bring them to bear in terms of advice to government.

The department I believe has really failed to provide a national strategy. It has not been a national strategy at all; it has only been a national strategy in name. State and territory governments have never been drawn into funding this approach or signing off on it in the way that other national strategies, like the national road safety strategy, which I referred to before, have been. That strategy was signed off by all governments and other stakeholders, such as the automotive engineers and others, to ensure that the whole sector is working to an agreed framework and plan. I believe the department has also failed to put in place basic monitoring, evaluation and reporting. The department has failed to release in a timely way reports in this regard. I refer specifically to the evaluation of the first national suicide prevention strategy from 2000 to 2004. That was an evaluation undertaken by Erebus Consulting. It was finished in 2005 but, strangely, not released until last year. That evaluation would have been incredibly valuable to the sector that contributed to it to ensure that as we go forward we are informed of where we have done well in the past and what we need to do better going forward.

The department has, for whatever reason—no reason has been given—refused to release the national bereavement strategy. I believe that they indicated in evidence that they provided here this afternoon that, because the states and territories were not part of the project, the release of a national strategy could not go forward. That is a contradiction to the approach that they have taken on the national suicide prevention strategy. It was done without any state involvement or sign-off at least at ministerial level. The states were involved. They chose to bury the national bereavement strategy and that is despite the fact that the reference group was appointed by them. It was chaired by Professor Beverley Raphael and every member of the national reference committee on the bereavement project was appointed by the department. They had the full cooperation of every state and territory. It did not require state and territory sign-off, but the cooperation had been already drawn in through the project processes.

There has also been a failure to release a project which I think has been critical to addressing some of the problems, which you will have been told about, in relation to people accessing both emergency departments and ongoing care after discharge from either an ED or an acute care unit. Work that was undertaken by the Hunter Institute—which actually did engage all the states and territories, in providing them with their models of care and their protocols in this area—has never seen the light of day. That is regrettable, because we know that in New South Wales alone, as reported by the *Sydney Morning Herald* in July last year, in the 18 months leading up to that report 175 people discharged from New South Wales ED and acute care psychiatric units took their own life within 28 days of discharge. We know very well, thanks to the work of auditors-general, ombudsmen and other independent statutory office holders, that this is an endemic problem across Australia’s mental health services: a failure to continue to provide care and track people, as Ian Hickie was pointing out today. A fundamental building block of an effective system would have been to put in place tracking mechanisms for continuous care.

One needs to see each of these failures in the broader context of a failure to provide strategic policy advice to government. Instead, the obsession with the department has been to micromanage minor projects. They are well-meaning projects, often well based on evidence, but not scaleable in terms of influencing the national picture—not scaled up, not systematically rolled out and not within a clear, strategic approach. What some have described as the ‘confetti approach’ has been the strategy of the department—that is, spray small amounts of money over a large landscape and hope that something changes. But the evidence does not support that as being a successful strategy.

In my view, the time has come for the department to be relieved of its responsibility in relation to suicide prevention, in the same way that the department of transport is not the sole custodian of road safety responsibilities. The Hawke government, way back in the early eighties, established a separate authority to take forward national road safety prevention. It provided a focus point for research, investment and coordination of activity. It is my view that suicide prevention transcends the boundaries of Health and Ageing at the Commonwealth level and, in fact, relates to the work of departments such as FaHCSIA, quite obviously; the Department of Human Services; DEEWR; Defence; and Immigration. All of these departments have a role to play in reducing the suicide burden across Australia. In my view, a statutory authority charged with responsibility for taking this issue forward in a strategic sense is absolutely essential to changing the outcomes that we have seen over the last 15 years since the first Suicide Prevention Strategy was established.

That is one of the solutions, but in the report—I will not go through them now—there are a number of other solutions or ways forward to reducing the burden of suicide and suicidal behaviour on the Australian community. But it does begin with two things: national leadership and coordination, a sustained strategic approach; and far better monitoring, evaluation and reporting. Much of that monitoring, evaluation and reporting needs to be independent. Too much of the evaluation and reporting we have had—there has been too little of it; that is true—has been, I guess, at the discretion of the funding agencies, and that is not a good situation to be in in a very contestable area such as suicide prevention.

I did also just want to mention before I pass over to questions that one of my other roles is that I chair an advisory group for the Industry Funds Forum mental health foundation. Just to make sense of that, the industry superannuation funds are organisations like HESTA, Cbus, UniSuper—all those ones that we see the former governor of the Reserve Bank encouraging us to invest in! They cover some nine million Australians for their superannuation and insurance requirements. Through that project that we are doing with the industry super funds, five of the funds have reported to me that, in looking at claims due to death by suicide, on average across those five funds the cost to the funds is nine per cent of all deaths claims, with an average claim payment of approximately $60,000. Now, the ABS data will tell us that the burden of disease due to suicide—that is, the number of suicide deaths out of the total number of deaths—is around 1.4 per cent on the published data to date. Leaving aside all the arguments about whether or not that is accurate—it is probably closer to two per cent—the death rate versus that cost in insurance I think also points to the fact that there is certainly an issue with the counting of deaths due to suicide. But it also highlights the fact that these deaths are occurring in people of employment age, and it is a high cost to our society.

One final thing I wanted to refer to, and it comes from a role that I perform at the other end of the scale, a very local role, is that I sit on a thing called the Mental Health Executive Council on the Sunshine Coast. It is a voluntary role where we at a local level try to do the best we can with the resources available to meet the burgeoning needs of one of the fastest growing regions in the country. It is not funded by anyone, but the groups involved include the Sunshine Coast Division of General Practice, Lifeline on the Sunshine Coast and other community mental health organisations, and it includes, in their own time, the acute care unit from Nambour Hospital and the child and adolescent mental health service. That division of general practice has received funding from DOHA for a pilot program to try to find pathways for people who do not gain admission to the ED or acute care unit in Nambour but clearly have a risk of suicide and need to be put in touch with services.

Now, this is a good thing in terms of funding a pilot, but, regrettably, no evaluation has been set up to monitor the effectiveness of this pilot. The funding has limited the ability of the agency that receives the funds, the division of general practice, to actually engage with public mental health services because the initial funding was 12 months, then it was extended for six months and now it has been extended for another six months. The acute care unit director has told me point-blank that they will not engage in a project of such short-term funding because they simply cannot afford the resources. So that unit based at the hospital, the most important public health facility on the coast for 300,000 people, has no ability to link into this pilot program. Lifeline and all of the other community service organisations that are part of this executive council likewise are excluded from participation in the program. They cannot refer any clients that they come into contact with who may need this service. The only referral pathway that has been established is through a handful, and I mean literally a handful, of GPs on the Sunshine Coast. So after 18 months, in December, that program had seen 89 clients—89 clients, when the project is funded at several hundred thousand dollars a year. That is a very bad buy from public funding.

This is not an isolated case. I am not picking this out because it amplifies my case about a lack of strategic policy direction from the department, but it is somewhat typical of very poorly structured funding requirements, overzealousness in terms of micromanaging projects that are put out there and setting them up in a way that really does not help us build an evidence base. There are many more things I could say, but I had better stop there because I am very mindful of the fact that you have to get on a plane to Brisbane shortly.

Senator MOORE—Professor Mendoza, in terms of the process, what do you think should happen?

Prof. Mendoza—I think firstly we need to recognise that in areas like HIV, road safety and breast cancer reduction, the impetus for that effort in the community—drugs and alcohol is another one—did not come from within health departments; it came from community organisations, universities, centres of excellence and others—and sometimes parliamentary inquiries—to actually change the way our nation responded to these issues.

My own experience in the alcohol and drug field is that in the 1980s the Hawke government threw what was then known as the drug offensive and the National Campaign against Drug Abuse. That led to some very important but relatively small-scale investments in infrastructure which built a research base which built an ongoing ability to train those people that are involved in that field and raise the collective capability we have in that field. I know Ian Hickie mentioned a little bit today about that, but just understanding the different subcultures in the alcohol and drug field has been incredibly important to the effectiveness of programs that we have put in place.

We have established some of the best ethnographers as a result in this country, ethnographers who can look at particular subpopulations and understand what the drivers are of those behaviours and what sorts of approaches we might take—very targeted interventions. A similar sort of approach has not been taken in relation to suicidal behaviour, and we need do to that because the motivations, if you like, or the circumstances that lead a 44-year-old man to take his own life or attempt suicide are quite different to those associated with a young person: a young woman, a young man or even a young child.

Children are currently not reported in our statistics. I certainly believe they should be. We do not know what the scale of problem is, but I agree with Ian’s point that it is not necessarily large in number but it is distressing. I do not believe that we have a good understanding of what is happening in relation to child suicidal behaviour.

So learning from that, the short answer is: we have to invest in new structures, new infrastructure and invest in what is truly a national strategy, not one that has got the name ‘National Strategy’ but a national strategy that engages not only the other eight governments in

Australia but the sector, the industries, the stakeholders who really want to see transformation in this area. At the moment those folk are not engaged in a decision-making way in the way that we go about this issue. If we compare it to those other areas, they are. If we look at road safety, the building manufacturers, the engineers are all engaged in that process. They all understand and have a part to play in the improvement of road safety in this country; it is not just left to our nine governments—that is point number one.

Secondly, the scale of the investment in suicide prevention is miniscule. I said in this report: it equates to 91c per Australian as opposed to several hundred dollars—nearly $800 per person—that it costs on a preliminary analysis of the data. So our investment in prevention is miniscule in terms of what it is costing our economy. We can seriously invest much more and do it very quickly. The scalability of effective programs is very easy do to in this area, and in 2006, when I was the CEO of the Mental Health Council and we were engaging with the government at that time leading up to the COAG decision in 2006 around the mental health plan, we certainly put the case that a 10-fold increase on the then $10 million investment could be easily dealt with. It was not reliant upon a workforce that did not exist.

We could actually scale up e-mental health programs, electronic and telephone based services very quickly. There is good evidence to support that. We could scale up tracking mechanisms, which Ian spoke about earlier. These are, if you like, investments in infrastructure, not human capital, which, in terms of specialist support fields, there are desperate shortages in. We could put in place mechanisms that ensured that every person who presents to an ED unit and is discharged from an acute care unit has, as a matter of course, a care plan. Yet, despite numerous reports from the Victorian Auditor-General in particular, who has inquired into this issue and kept tracking it for a number of years, we still see a huge number—and I am talking of at least 35 per cent in that state, which is the best-performing state, and much higher rates in my own state of over 50 per cent—of all discharged patients not being seen at all following discharge. Recently, in a program in Mackay they were hoping to achieve one follow-up for every client who went through the acute care unit within 28 days of discharge—about 800 clients go through that unit each year—and they were not even achieving that benchmark. So we have a long way to go. But we can do these things tomorrow, with fairly small-scale investment.

Another thing that I think the Senate needs to consider is the fact that about one-third of all suicides, based on current numbers, are of people who have recently had contact with acute mental health services. We know that, along with problems with access to care, the quality of care is a key factor. Unless we address the state of our public mental health services around this country, we will not change that proportion of suicide. I suppose one of the difficulties in addressing this issue is that, somehow, we have to, again, engage the states and territories in how to reform their mental health services, instead of continuing to do what they have done for the last 17 years. That is, perhaps, a starting point.

Senator MOORE—One of the issues that has come out consistently in the evidence is the lack of any coordination. With respect to the investment that has been occurring, people do not seem to understand or know what has been going on, and these are people who are actively involved in the sector. We were told today that a lot of the data is kept at the CSS in Melbourne. What is your understanding and knowledge of that centre?

Prof. Mendoza—Crisis Support Services are the service that is contracted by the department of health to do these so-called LIFE communications, which are essentially communications to the sector on suicide prevention activity. They are also a service provider in a number of other contexts. They provide services to the Victorian Department of Health, such as a suicide helpline for that state. They are contracted to FaHCSIA for MensLine Australia, which takes about 100,000 calls a year. But what is that data telling us about the trends and the issues? If you take the MensLine, I think there is an enormous repository of information—

Senator MOORE—Knowledge, yes.

Prof. Mendoza—We do not have a clue in terms of publicly accessible information. Regrettably, the contracts of the federal departments—and, increasingly, this also applies to the state departments—invariably, do not allow those contacted providers to release that information publicly. So the information has been released at the discretion of the department. That blinds us all as to what is actually going on. What are the emerging trends that are coming through from the callers on that MensLine in terms of issues for men living in rural and remote areas, other men, or their partners, so that we can actually start to target interventions?

This is part of the rationale that I and others have put forward as to why we need to create a body that is statutorily responsible to the parliament for national leadership, coordination, monitoring and reporting on what is happening in relation to suicide and not allow that organisation to filter and withhold information that is critical to us as a community dealing with this problem. That is why I think having it within the auspices of a Commonwealth department, as opposed to a Commonwealth statutory authority, becomes troublesome in terms of the release of data, because departments are under the responsibility of a minister, whereas statutory authorities can be somewhat at arm’s length from a government and can have in their act clearly defined responsibilities and reporting requirements to the parliament. That is a really important issue that will help us move forward on this issue, as it has helped, as I say, in some of these other areas.

Senator ADAMS—I would like to get the total financial cost. Was that $17.1 billion that you—

Prof. Mendoza—It is $17.5 billion, and I would be the first to admit that a lot more work has to go into this. But, in the paper that I will table for you, it is based upon work that has been done in the costing of road deaths, so it is a robust formula that has been applied in that context. Then, using the available ABS data—in particular in terms of the numbers of Australians that report making a suicide plan or engaging in suicidal behaviour—and the AIHW data in terms of hospital admissions related to self-harm, if we take all of those inputs, we can start to get a sense of what that cost is. But more work has to be done on this, and my best estimate of the cost to the Australian community of suicidal behaviour would be between $15 billion and $20 billion. It would be in that range. It is a big number in GDP terms, leaving aside the social and personal impact.

As I say, our investment in addressing this and reducing it has been minuscule, it has not been well targeted and it has certainly not been well monitored and reported. We have to do a lot better. We could increase that investment tomorrow to $100 million, and we would only just be starting to put in place some of the basic building blocks for addressing this problem. I think we have to learn from how we have tackled other cross-jurisdictional issues. This is not just a health issue, in the way that road safety is not just a health issue. It impacts on health departments, absolutely, but reducing the burden of disease from road trauma has been best driven, at least in those early years, by putting it under the authority of a well-resourced body, accountable to the parliament, and I think the same sort of lesson can be applied in this regard.

Senator ADAMS—Were you here when I asked the questions of the department about their economic modelling?

Prof. Mendoza—I was not here for that, no. I am sorry.

Senator ADAMS—They will be coming back to us with, hopefully, some better understanding of how these things are done, so that should be relevant.

Prof. Mendoza—I would hope that before your inquiry is concluded—or at least before it is down to the report writing—I would be able to provide you with a much more robust economic analysis involving one of the best economic modelling organisations in the country. I am not an economist, and I will rely upon their input and their model, which they have applied in a number of contexts, to give a much stronger basis to the number that one might assert is a result of suicide and suicidal behaviour.

Senator ADAMS—And you will have that finished before—

Prof. Mendoza—I am hoping so. I do not want to be held accountable for that. I am doing it, basically, through contributions and donations from organisations to pay for that. I have not quite got enough money in the bank yet to make it happen, but we will get there.

Senator ADAMS—Thank you.

CHAIR—Professor, you have been very expansive in the answers that you have given so we have covered a lot of ground. I want to go back to the strategy and to your comment that you do not believe that the strategy itself was developed with the states. Can you expand on that a little bit?

Prof. Mendoza—Sure. The National Suicide Prevention Strategy had its origins in the Youth Suicide Prevention Strategy, which was put in place by the Keating government in 1995. The Howard government moved, quite rightly, to expand that to a broader strategic framework in 1999 and established the National Suicide Prevention Strategy from 2000. Being called the national strategy, that implies and means that in general public policy terms the states and territories have been part of the development of it and they have signed off on it, and they are often identified as contributing particular components or as undertaking particular actions. That has not happened. So it is called a national strategy but it has been a Department of Health and Ageing strategy entirely. To the best of my knowledge, even those departments outside of Health and Ageing have not actually been drawn in to sign off on that. In those early years it was roughly a $10 million per annum investment by both the Keating government and then the Howard government until 2006. When the release of the COAG National Action Plan on Mental Health occurred it was boosted to $20 million. My point is that it could have gone to $100 million at that stage and we would have gained enormously. It was not reliant upon more evidence. It was not that we did not know enough. We certainly did know enough to make sound strategic investments that would make a difference. We could have done that then and we can do it now.

CHAIR—In terms of the bereavement strategy, we heard—and I know that you mentioned this before—earlier from the department that it was not released because the states had not been consulted over it but that since then the department has put out the bereavement pack, which was released only last month. Have you had a look at that and do you have an opinion about why the strategy was not released?

Prof. Mendoza—As to the second part of your question, I have no information as to the reasoning why the bereavement strategy was not released in 2006, when it was completed. The consultants who undertook that work have advised me that they have no explanation, and the sector has no explanation as to why it was never released and acted upon even though it was requested numerous times. As to the bereavement package released last month, no, I have not had the opportunity to review that.

Senator MOORE—Were you advised of that release and sent copies and told about it?

Prof. Mendoza—No.

CHAIR—Can we do a straw poll of those down the back. Who knows that it has been released? People down the back, we are doing a straw poll of you. Who knows the bereavement pack was released last month? I just need a show of hands. None.

Senator MOORE—We were interested, given a process that has had such a long history, whether something that was released last month was widely promoted and discussed.

Prof. Mendoza—I might be the Chair of the National Advisory Council on Mental Health but that does not mean that I would be advised of these things.

Senator MOORE—You aren’t the joint member of both?

Prof. Mendoza—Sorry?

Senator MOORE—I asked earlier about the relationship between the Advisory Committee on Mental Health, the minister and the advisory committee on suicide to the minister and the answer I received was that there is a joint member and that there was free interchange. I do not want to verbal anyone but it was said there was free interchange between the two groups.

Prof. Mendoza—The National Advisory Council on Mental Health, which I chair in a different capacity, is an advisory body to the government and to the minister. I can say that we are required as members not to share between committees. We are bound by not one but numerous confidentiality agreements. In fact, at one stage I thought I was signing them more often than I was changing my clothes. There are requirements that prohibit us from sharing information across those committees. I have had one meeting with Professor Ian Webster, who chairs ASPAC, but Dawn O’Neil, who is a member of both the National Advisory Council on

Mental Health and ASPAC, is unable, as I understand it, to share information between the two committees.

CHAIR—Maybe we will be asking Ms O’Neil that next time we see Lifeline. I have one final question. I was interested in the department’s response on the ATAPS. I do not want to verbal the department, but if I interpret what the department was saying about ATAPS, it was that they saw that as a vehicle for dealing with quite a lot of the issues around helping people outside the acute care system and EDs. They see that as a way of dealing with some of the issues that you have raised. What is your experience with the ATAPS process? Have you been involved in previous evaluations? Are you aware that it is currently being evaluated again?

Prof. Mendoza—I am aware that the department has recently undertaken a review of ATAPS.

CHAIR—It is another evaluation as well, isn’t it?

Senator MOORE—Through the Hunter.

Prof. Mendoza—I am aware of some of the evaluation that was produced under the Better Outcomes in Mental Health Care initiative, which was instigated by Michael Wooldridge when he was minister for health. Regrettably, the evaluation of better outcomes was curtailed by the department. We did not evaluate all of the components of better outcomes, regrettably, because there were many innovative aspects of that. I think it would have enabled both the previous government and the current government to make decisions in relation to the better access program with a better evidence base. But ATAPS as a general initiative is a very positive one in terms of enabling people who may not have the means to access services through private insurance or be able to afford the typical gap payments that are necessary. That is certainly one of its features. Its other key feature, I think, is that it does build a much closer collaboration between allied health and general practitioners and it has a requirement on general practitioners to have a higher standard of training in relation to mental health issues and recognition of suicide and suicide assessment. So those things are good.

But, again, like too many of the programs in this area, it is simply not at the scale where we can see a national impact. Almost every division that I have spoken to over five years reports oversubscription to the available ATAPS funds. That has been corrected in recent times to some degree. But take that example from the Sunshine Coast: a pilot program funded under ATAPS, in the division of the Sunshine Coast, specifically for those people who were not seen to be unwell enough. This is one of the other curiosities in mental health: you have to be at the point of self-harm and imminent risk to yourself or others in order to get admission to virtually any acute care mental health unit in Queensland. It is much the same in New South Wales and other jurisdictions.

CHAIR—It is across the board.

Prof. Mendoza—Yes. The whole purpose of this pilot was to link these people into primary care and other specialist community care to enable them to have continuous support and to recover. Regrettably, the parameters around the way the program has been funded, with short stints of funding, have not enabled that connection with the acute care unit and have not enabled any connection with community services. So it is down to GPs who may have a link with some allied health providers to provide a range of service options to the individuals concerned. But we will not know whether it is effective or not because the division has not been funded to evaluate it.

CHAIR—Whose idea was that trial?

Prof. Mendoza—I do not know, but it is managed by the department.

CHAIR—So on the board that you are on, on the Sunshine Coast, it was not an issue.

Prof. Mendoza—No. Everyone there is losing their hair literally over the frustration we have with these sorts of ridiculous parameters. One of the biggest problems we have in Australia, as you are well and truly aware, is service coordination between what states and territories fund and what the Commonwealth funds. We have ridiculous overlaps and duplications of service, and then we have massive gaps. As one consumer that I work with regularly describes it, it is a lucky dip out there if you can get any access to mental health services. It is a really lucky dip if you get access to quality mental health services, ones that actually are effective. In this area, in relation to people experiencing suicide ideation and suicidal behaviour, it is even a greater lucky dip to actually score the sort of service that is going to work. As Ian Hickie and Sebastian Rosenberg referred to, the ABS tells us there are 65,000 attempted suicides a year in this nation, one every eight minutes. How many of those people are actually getting in touch with care? We do not know, but my guess is the vast majority do not and continue to be at risk.

CHAIR—If 50 per cent of people who end up in acute care or EDs are getting follow-up service—

Prof. Mendoza—That is the best available evidence I have in Queensland. The Victorian Auditor-General’s most recent report says around 30 to 35 per cent are still not getting any continuity of care.

CHAIR—Lifeline’s submission said on average it was 41 per cent across Australia.

Prof. Mendoza—Yes, it is an issue across Australia.

CHAIR—You would guess that some states are lower than 41 per cent if Queensland is at 50 per cent.

Prof. Mendoza—Again, these patchy reports that we have from statutory office holders like auditors-generals, ombudsmen and public advocates do not give us a good picture or a sense of confidence that we are actually making progress in relation to access to care, quality of care and continuity of care for people that are highly at risk. Mental health is not a cause of suicide but it is one of the greatest risk factors. We know people on discharge from acute care are at extremely high risk, imminent risk. The evidence shows that, yet we still fail to put in place even basic continuity of care for them. To me, that just highlights the failure of the strategic policy setting, monitoring and evaluating that we have had for a long time now.

CHAIR—Thank you very much for your submission and evidence. Your time is much appreciated.

Prof. Mendoza—Thank you, and I will table the economic costings.

CHAIR—The committee will adjourn till nine o'clock tomorrow morning in Brisbane.

Committee adjourned at 4.58 pm