COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Suicide in Australia

WEDNESDAY, 3 MARCH 2010

SYDNEY

BY AUTHORITY OF THE SENATE

SENATE COMMUNITY AFFAIRS
REFERENCES COMMITTEE
Wednesday, 3 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: Adams, Bilyk, Boyce, Coonan, Furner, 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 9.06 am

BATEMAN, Ms Jenna, Chief Executive Officer, Mental Health Coordinating Council

HENDERSON, Ms Corinne Deborah, Senior Policy Officer, Mental Health Coordinating Council

CHAIR (Senator Siewert)—The committee is continuing its inquiry into suicide in Australia. I welcome representatives from the Mental Health Coordinating Council. I understand that you have both been given information on parliamentary privilege and the protection of witnesses and evidence. I acknowledge that we are meeting on Aboriginal land. Thank you very much for your submission. I invite you to make an opening statement.

Ms Bateman—Thank you for the opportunity to present to the committee. We have a short presentation to begin with. I will do the first part of it, and then Corinne Henderson will do the second part. We are going to talk on three key areas that we think are of particular importance. The first one is a stigma and discrimination for people with mental health problems. The second is post discharge and post release. The third area that we will speak about is the impacts of child abuse.

Firstly, stigma and discrimination. Frequently people at risk of suicide are very isolated from society. Whilst the medical profession is important in managing suicidality, MHCC emphasises the significance of adopting an approach that enhances social cohesion. This is only achievable by embedding a flexible community managed approach into service delivery that provides the social connectedness and glue that help communities become inclusive and resilient. Where suicide prevention activities are concerned, it is necessary to target areas likely to have the greatest impact on building resilience, promoting social inclusion and generating attitudes of tolerance and acceptance towards people generally and particularly towards people with mental health problems. To minimise stigma and discrimination, approaches must raise awareness through media and community campaigns and build capacity at an individual and service level.

Australian mental health consumers have identified discrimination as the single largest barrier to their recovery. Discrimination against people with mental illness is recognised as a priority issue in all English-speaking OECD countries. National campaigns on mental health exist in Scotland, England, New Zealand, the USA and Canada. Australia has a relatively poor track record in this regard. Even the work done by Beyond Blue in relation to depression pales against campaigns in other countries which have positive social inclusion campaign approaches to high-prevalence and low-prevalence mental health problems. Research in the UK has found an investment in stigma discrimination campaigns of 55p per adult can produce a cost saving of £4.51 per person. This is an 800 per cent return on investment. Reducing discrimination increases the likelihood of people seeking support and treatment and leads to improved employment and education opportunities. Australia must invest in a clear and positive national stigma and discrimination media campaign comparable to other Western nations. The one developed in Scotland in particular I think is worth noting.

Alongside a national media campaign to raise awareness, it is necessary also to support community initiatives specifically targeted at school students, teachers, counsellors and vocational community staff working with children and young adults and Child Support Agency staff. These initiatives would not be dissimilar to a Road Traffic Authority drink driving campaign but instead would help people identify and respond to those who may be at risk of suicide and self-harm.

MHCC also recommend a prevention, early intervention, evidence based model based on a US program called Family Options. This takes a family centred, strengths based approach to dealing with mental illness, parenting and family relationships. The program partners with people with mental health problems and their families, assisting to build networks of supports and resources. The aim is to strengthen the long-term mental health, wellbeing and functioning of all family members. The program provides personalised support to each family member as well as the identified adult or child. Under this model, families and individuals are supported by a family coach, ensuring service coordination across a diversity of services they need, which will vary of course over time.

The second area that I will speak about is risk of suicide post discharge and post release from prison. Data from the ABS in 2007 tells us that suicide deaths in Australia represent 1.3 per cent of all deaths and that for Aboriginal people this figure climbs to 3.7 per cent. These figures may be substantially higher for both Aboriginal and non-Aboriginal people if unexplained vehicle accidents and other accidents were to be included. Mental illness is recognised as a significant risk factor for suicide. The review of research and evidence states:

> A diagnosis of a mental disorder is among the strongest risk factors for both non-fatal and fatal suicidal behaviour ...

and that coexisting mental health and drug and alcohol problems increases this risk even further. Over the past 20 years, the chronic problem of post discharge suicide remains a significant concern worldwide. Reported suicide mortality rates are 213-fold higher than the general population in the first 12 months after discharge from inpatient care. These figures need not be so high if adequate levels of ongoing community support services are put in place. Existing evidence suggests that post discharge suicide fatalities appear to cluster, with up to 80 per cent occurring within the first year, 48 per cent within the first month, 28 per cent within the first week and 13 per cent on the actual day of discharge. This kind of research must inform service design if we are serious about reducing suicide rates.

Suicides in jail receive considerable attention from prison authorities. Programs and policies are in place to minimise the risk of suicide during incarceration. In contrast, far less attention is paid to the post release period, when the duty of care shifts from the custodial authorities to the community. Studies suggest that the initial adjustment period after release is a time of extreme vulnerability, particularly for men. On return to the community, variables associated with suicide, such as hopelessness, significant loss, social isolation, lack of support and poor coping skills, are especially significant for this group. An Australian study of recently released prisoners found that in the immediate six-month post release period the suicide rate is three times higher than in the general population.

One recommendation for this inquiry to pursue is access to psychological counselling for prisoners to assist them to work through their issues and plan and explore how life after prison will be. Whilst convicted persons are eligible for Medicare benefits whilst in jail, the Health Insurance Act 1973 precludes them from accessing these benefits on the grounds that they have access to services provided by arrangement with a government authority—in this instance

Corrective Services New South Wales. However, whilst some psychological services are provided through Corrective Services New South Wales, they do not fulfil the need, as evidenced by the justice health inmate survey 2009, which shows very high rates of mental illness and psychological distress. We recommend the expansion to psychoeducational group and evidence based individual interventions be provided in jail and the shortage of clinicians in corrective services to be supplemented by the Commonwealth agreeing to provide MBS psychological services to inmates.

MHCC also recommend a national expansion to the HASI program, which is designed to assist people with mental health problems requiring accommodation support to participate in the community, maintain successful tenancies, improve their quality of life and, most importantly, assist in their recovery from mental illness. Similarly, we propose an expansion of the HASI model to provide a home for recently released inmates with mental illness and/or coexisting mental health and drug and alcohol problems. This would greatly reduce the risk of suicide post release for this vulnerable group.

MHCC, likewise, recommend expansion of the FaHCSIA funded Personal Helpers and Mentors program that reduces risk of post discharge and post release suicide. PHaMs aims to increase opportunities for recovery for people whose functioning has been impacted by mental illness, providing the flexibility in service delivery that people need. Under the PHaMs program, people can, for example, access support to help them manage everyday tasks or assistance in finding alternative or more appropriate accommodation, support to access clinical care and access to employment, education and training opportunities, help to reconnect with family and friends, and increase social networks and community involvement. For those at risk of suicide these services may be the critical circuit-breaker of social exclusion.

I will now hand over to Corinne Henderson, who will talk briefly on the impacts of childhood abuse.

Ms Henderson—Sexual, physical and emotional abuse, neglect and exposure to domestic violence have significant mental health repercussions. Adult survivors of childhood abuse consistently manifest high rates of mental illness and suicidality. Childhood sexual abuse was responsible for 0.9 per cent of the total burden of disease and injury in Australia in 2003, and 94 per cent of this burden was due to anxiety and depression, suicide, self-inflicted injuries and alcohol abuse.

Suicidality has been associated with childhood abuse in a number of studies and in one study 16 per cent of survivors had attempted suicide compared to six per cent of their non-abused cohorts. One study found that 80 to 85 per cent of women in Australian jails have been victims of incest and other forms of abuse. Another study of 27 New South Wales correctional centres found that 65 per cent of male and female inmates were victims of child sexual abuse and physical assault. According to the 2008 New South Wales inmate census by Corrective Services, women represent approximately 7.3 per cent of inmates, of which 29 per cent are Aboriginal. The survey found that 27 per cent have attempted suicide.

The abundance of international and Australian evidence identifies the barriers to service delivery adults survivors of childhood abuse almost universally experience. Their complex needs often overwhelm the capacity of mainstream services. We recommend that, in order to address this gap, community managed organisations must be supported to provide practical assistance, such as establishing an income, counselling, suitable accommodation, clothing and other resources, health care, legal services and providing for children’s needs as well as programs that address domestic violence, gambling, substance abuse and other counselling services.

Some women’s health centres and refuges already provide a diversity of support services through linkages to other community managed organisations, but these services are scarce and underresourced. There is a need to support community managed organisations to build skills to enable the workforce to better engage with its client group. Research including that which MHCC conducted in 2006 confirmed that adult survivors need access to long-term counselling and psychotherapy. The availability of short-term access to psychologists and social workers through the MBS scheme of six to 12 sessions generally does not meet the psychotherapeutic needs of most survivors. In line with the government’s strong theme of social inclusion, funds should be allocated to community managed programs that provide individual therapy and connect people to support and psycho-education groups. MBS funds could be used to provide psychologists and other specialist allied professionals if there were greater flexibility around national accreditation schemes for professionals other than psychologists to undertake this work.

Finally, MHCC strongly recommends the need for a targeted national strategy as suggested by the joint submission initiated by Lifeline Australia and Suicide Prevention Australia, which MHCC endorsed. In the absence of a clear national strategy, it is unsurprising that roles, responsibilities and accountabilities are poorly defined. Further, like in any other cross-jurisdictional and cross-portfolio issues, there is no agency at a national or state and territory level with a mandate to address suicide and suicide prevention. This is in stark contrast to the infrastructure, clear strategy with targets and regular public reporting on progress on investment in road safety, which has a lower number of deaths notwithstanding the underreporting problem with suicide data.

Senator MOORE—I have got two questions and I will put them out there and you can go with them, because we are very short of time. The first is about coordination of services. By the nature of your name, I know that is a very important part of the work and the effort that you put in regularly to try and get this up. There have been a number of complaints that services for suicide and suicide tendency are very low. You pointed to the post release issues. Do you have any ideas about how we can actually look at coordinating services better across all levels of responsibility in government and also the NGOs?

The other question is to do with your last point about the targeted approach. Are you recommending that there be a separate agency a la the road traffic authority, which has come up in other submissions, to look specifically at these issues, or rather that one of the government agencies, such as Health and Ageing, which in my opinion has the responsibility in the current process if you trace it all through, is beefed up?

Ms Bateman—Care coordination is an incredibly important area and one that we seem to not be particularly good at getting right. I guess care coordination works if you have enough services, and I think that that is probably where I would start in answering that question. I think we have inadequate access to services, particularly when people leave hospital. That clearly means that you lose people. People fall through the gaps because there are not enough pathways to ongoing support. In New South Wales we do have some very good programs. The HASI program which we mentioned, for example, has shown very good outcomes. However, it only works for the people who are in that program and the numbers in that program are actually fairly low compared to the need. The PHaMs program is able to pick up a slightly different cohort of people, but again that program could be doubled and you would still be probably needing more. It certainly needs doubling at this stage. So care coordination needs adequate services, and I think that is where we have to start.

Relationships between area health services and community-based sector, the NGOs, vary. There are some good relationships that work particularly well. Others fall by the wayside or are not prioritised by area health services. They are seen as secondary, they are not necessarily seen as complementary, and I think we really have to try and shift that thinking. The community-based services are complementary to clinical services and they are very necessary part of the mental health service system.

The second question was about the roads traffic authority. When we talk about some of the successes of the roads traffic authority, we are looking really to their national campaigns; the reduction in deaths which have occurred through some of their advertising campaigns seems particularly successful. I guess we are putting them forward as a model in that regard for stigma and discrimination reduction campaigns. I agree with you that we already have DOHA and DOHA could take a lead in this area. They do not, is the bottom line. So when a department fails to take a lead in an area that has clearly demonstrated in OECD countries to have significant impact, when they fail to understand that and act appropriately then you look for other sorts of mechanisms to achieve the same ends.

Senator MOORE—Can you give us an example? I mean, Ms Henderson’s last couple of paragraphs were talking about that targeting, the need for a lead. It is your view that DOHA is not fulfilling that. Can you tell us why you do not think so and some examples to back up that statement?

Ms Bateman—What I am referring to particularly is the lack of a national stigma and discrimination reduction campaign in Australia.

Senator MOORE—That is the focus of your belief that it is not being well led.

Ms Henderson—We do not really have one.

Senator COONAN—A point that particularly interested me was the real difficulty in dealing with stigma and discrimination. I was going to ask you what you would see as a national strategy and a national model? How would you actually go about it and how would you deal with things like workers compensation insurers, various agencies that are dealing with people who have mental health issues being able to help them get back into the workforce, because seems to be one area in particular that is a real barrier to people being well, that there is no real understanding of how their condition may be able to be really helped if they can have a job and hold down a job. Often they cannot even get one because of the discrimination, if they have had either an existing condition or one that manifests itself in the workplace.

Ms Bateman—I agree entirely, and definitely the research supports that view. Your first point was about what a national stigma discrimination campaign would look like. As I said, we can look to Scotland and New Zealand. Their campaigns are fantastic.

CHAIR—The Scots have been mentioned a number of times.

Senator MOORE—The Scots have been applauded on many occasions.

Ms Bateman—They are fantastic in mental health.

Senator BOYCE—Cross out Scotland and insert Australia was one of the suggestions we have had.

Ms Bateman—And you think, how come Scotland got it right?

Senator COONAN—I apologise to my colleagues because I am new to the inquiry, but what is so good about the Scottish system, the Scottish model?

Ms Bateman—They just seem to have a very good grasp of what social inclusion is and a very good understanding that mental health is not necessarily something that excludes you from participating and leading a normal and engaged life, that it is a difference that some people have rather than something that is kind of wrong with you.

Senator COONAN—It is not disqualifying.

Ms Bateman—Yes, it is not disqualifying.

Senator COONAN—How did this come about in Scotland? It seems to me that you need very strong leadership to be able to conceive of this kind of strategy—to brand it, deliver it, and hang on to it.

Ms Bateman—That is a bit of a mystery to me. I am not quite sure how it came about. I was just alerted to it when I saw their stigma and discrimination campaign, which is a broad based campaign that uses media, television, advertisements. It is that level of campaign.

Senator MOORE—Do they use sport?

Ms Bateman—Yes, sport; that’s right.

Ms Henderson—It is also a campaign that really celebrates diversity. It takes it on to a different level. It looks also at the achievements that people are able to make despite whatever they are experiencing. So it is not just talking about supporting people and being accepting and tolerant. It is actually saying there are some really successful people out there who have overcome this and that we really need to acknowledge some of that as well.

Ms Bateman—Yes. Moving on to the employment question, it has been a rocky road in terms of the services and supports that are available to people with mental health issues trying to access the workforce. Over the last 10 years we have seen a different focus as to how support is provided—say, through funding schemes such as DEEWR. In the early 2000s there were programs called ‘intensive assistance’ under DEEWR which were for people with mental health problems to work in community based organisations and gain support to enter the workforce. Those programs were defunded and a more generalist approach was taken. I think there was a loss to the mental health community generally through that process. We have not really seen it improve greatly up to now.

There is the national employment disability strategy underway now and there are some programs under that which will target employment for people with mental illness, but these have not fully hit the ground yet. We are yet to see the outcomes of that direction. My main point is that I do not think we have enough focus on enough services out there. We tend to not understand enough about the distinct needs of people with mental health problems and to design services appropriately. It is a different skill set to other sorts of disabilities and I do not think that is properly recognised in the way those services are currently designed. There is not enough emphasis on those differences and how you keep someone with mental health problems in the workforce.

Ms Henderson—Just to follow up on what Helen Coonan was saying, there is also a limited focus on supporting people in the workplace with mental health issues. Although somebody who has had a critical incident might be supported through WorkCover, it is a return-to-work model and it is very, very limited. Unless they are able to get assistance elsewhere—and some people can get some limited assistance through the MBS scheme—there is not really a culture that supports people in the workplace. Lots of nice statements are made but, unless there is a national campaign where people really get the message, it remains something that people tend to be very secretive about in the workplace.

Senator COONAN—There is good reason to be, I suppose.

Ms Henderson—That is right.

Senator COONAN—But it should not be like that.

Ms Henderson—It should not be any different to any other illness that people are not ashamed of having, but there is tremendous shame around it and a fear that they will be sidelined if they actually expose the problems they are having.

Senator FURNER—Yesterday we heard evidence in Brisbane from the commission for children and youth regarding the quality of the data that has been collected for suicides. I am wondering whether you can rate the contemporary suicide data collection and distribution to professionals and governments. What happened in Brisbane was that the commission identified a lack in data collection as opposed to the ABS collection. It tested that it was twice as high in Queensland compared to the ABS data.

Ms Henderson—Isn’t that around the demographic? In the Northern Territory suicide is much higher.

Senator BOYCE—This is two government organisations measuring the same events.

Ms Henderson—I do not know how that data was collected. The data is quite ambiguous anyway because so many deaths are ambiguous. I do not know. We would have to have a look at that.

Senator FURNER—Can I quickly get the reference from the comment that I think Ms Bateman made about the suicides post release, that in that first six months they are three times higher than the community.

Ms Henderson—We will put through what we have submitted today with the references. Are you talking about the post discharge suicides fatalities into cluster?

Senator FURNER—That is correct.

Ms Henderson—That was from the *Australian and New Zealand Journal of Psychiatry*, ‘Suicide after discharge from psychiatric inpatient care’. But we will give the full details.

Senator BOYCE—You have commented in your submission that there is a need for adult survivors to have the option to be referred directly to community services rather than via clinical services. I am presuming that this would mean an extension of the Medicare provider numbers and the like. Can you explain how you would see that working?

Ms Henderson—If community managed organisations were supported to have therapeutic services—within women’s health centres or other similar kinds of organisations—then psychologists, counsellors and psychotherapists could be funded under the MBS to go into those organisations. They would be a place for them to go where they could actually provide those services, and people could self refer as well as being referred through other agencies. So it is a very accessible way of people finding those services rather than always having to go to the GP. Quite often GPs are not really all that well aware of what is out there anyway. That is part of the problem. The sector needs to be better linked to those primary care services.

Senator BOYCE—Of course the government response to that would be that you are just creating a huge level of demand that Medicare, for instance, could not sustain.

Ms Henderson—The need is there and it is a need that has really been ignored. The numbers are just massive. You are talking about one in five women and one in seven men who have been abused during their childhood. The impact of that is absolutely enormous. The services out there are almost non-existent. Just recently in New South Wales Rape Crisis have been funded to provide the equivalent of one counsellor to provide services at women’s health centres for adult survivors one day a week, so it is the equivalent of one FTE across New South Wales.

Senator BOYCE—He or she will be very busy.

Senator ADAMS—I would like to comment on your submission highlighting the need for teachers, school and pastoral counsellors to understand the dynamics and prevalence of childhood trauma. Does the chaplaincy system in New South Wales accommodate this sort of thing? Have you had much to do with the School Chaplaincy Program?

Ms Henderson—I do not think that the School Chaplaincy Program really covers that area. I do not think those people currently have the skills. It would be necessary to build their capacity to do that work. I am not sure that that is necessarily—

Senator ADAMS—But wouldn’t the school chaplain be the first person that a child having problems would go to in dealing with it?

Ms Henderson—The preference would be that it would be a counsellor as opposed to a chaplain.

Senator ADAMS—Do all your schools have counsellors?

Ms Henderson—Most schools have counsellors, yes.

Senator ADAMS—Even the small ones, the rural ones?

Ms Henderson—That I am not sure of.

Ms Bateman—They have access to counsellors if not actually counsellors in situ.

Senator ADAMS—And it takes six weeks for a counsellor to get there, often, so what happens in the meantime?

Ms Henderson—Then you have to upskill the people that are there to work with that client group, that area, to understand what the context is.

Senator ADAMS—I would have thought that if the chaplaincy program was alive and well in a school that might possibly be the key person to support.

Ms Bateman—I think you need skilled counsellors. It does not really matter who does it as long as they have skill in that area.

Senator ADAMS—I have a quick question on step-down facilities in New South Wales. You have commented on the Victorian model.

Ms Henderson—The park model, yes.

Senator ADAMS—Do you have many step-down facilities in New South Wales?

Ms Bateman—No, we do not. We do not have the park model in New South Wales at the moment. That is a gap in the service system in New South Wales. The park model is also a step-up model, so it does both. Step-up is even less apparent in New South Wales than the step-down. Something that we talk to New South Wales Health about quite frequently is that we need to begin looking very seriously at that model to fill that gap and keep pressure off inpatient units. I think there is a great potential for step-up programs to reduce some of the impact on the acute inpatient services.

Senator ADAMS—I think there is one for the step-down ones too, as a halfway house—

Ms Henderson—Absolutely.

Senator ADAMS—so that a client going out is at least being supported until they are in a state where they can move on with a case manager into the community properly.

Ms Bateman—New South Wales have taken the position of moving people through the non-acute inpatient system. They have funded a clinical non-acute inpatient program but not a community based program in this regard. It is a different approach.

Senator ADAMS—An accident and emergency—

CHAIR—You said you had one question and we are way over time, which means I have missed out on asking any questions. I thank the witnesses very much for both your submission and your evidence, as well as the question about your references that you took on notice. That is very much appreciated. For the entire week we have run out of time with each of our witnesses and we will continue to do so.

Ms Henderson—If you have any other questions you can always email them and we can send you a reply.

CHAIR—I do have several questions, including one you might take on notice. It is around the discharge issue which is coming up everywhere. In Queensland yesterday we were talking to the department about a system that two divisions of general practice are trialling looking at a link between the hospital and the division of general practice where there is a care plan—and each person who leaves hospital is supposed to have a care plan. This link is meant to ensure that the person being discharged gets follow-up. Are there similar trials in other parts of Australia? Is there a similar service here? What do you think of that service?

Ms Bateman—No, I do not think there is. It is not one that I am familiar with. Divisions of GP do not operate in that way here at this point in time. I would be concerned about that model because the kind of support that many people need when they are discharged from in-patient care is not only clinical support; they need social support. They need someone who will walk with them through their reintegration into their community. I do not think that is a clinical undertaking. I think it is about social support. That model will fall short unless it is also able to incorporate a social aspect.

Ms Henderson—It is very important for that to be some sort of case manager who links to those community services.

CHAIR—Perhaps we could give you the *Hansard* from a discussion that we had in Queensland. If you could comment on that, they would be appreciated.

Ms Bateman—I would love to.

CHAIR—This is an issue that is coming out absolutely everywhere. It seems to me that it is one of the key issues we need to look at.

Ms Bateman—Great. Thank you.

[9.46 am]

KELLY, Professor Brian, Professor of Psychiatry, Centre for Rural and Remote Mental Health, University of Newcastle

CHAIR—Welcome.

Prof. Kelly—Thank you. I would like to add that I am a member of the Australian Suicide Prevention Advisory Council. While I am not here representing that group, that may be relevant to questions that arise. I understand that the committee will be meeting with representatives of ASPAC at some stage.

CHAIR—I understand that you have been given information on parliamentary privilege and the protection of witnesses and evidence. We have your submission. I invite you to make an opening statement, if you wish, and then we will ask you some questions.

Prof. Kelly—I will be brief. Firstly, with regard to the context of the Centre for Rural and Remote Mental Health—this may put the submission into broad perspective—the centre has been funded by New South Wales Health since 2001 as an initiative to improve research, education, service development and planning around rural mental health. It is coordinated by the University of Newcastle and conducts core programs addressing those three areas of research, education and service development. It also undertakes projects through external grants, for example, from the Department of Health and Ageing, the NHMRC or other contracted programs through the New South Wales government. It has a broad focus and set of objectives.

As you will see in the submission, one of the areas the centre has been very actively working in is around groups at highest risk of suicide in rural areas. One particular group is the farming sector. The work that has been done has attempted to address a number of issues pertinent to that population but also to other populations in general. That is around the issues of not only the stigma of mental health but also the stigma of mental health services, improving access to effective services through coordinated pathways of care, increasing the responsiveness of the gateways to care—understanding that we are dealing with an often isolated population—and increasing the capacity of the specialist mental health sector to respond to high-need populations that may not access their services very frequently. That has involved coordination at a very local level of service networks where we can build a better understanding of what each agency is doing, how they can work more effectively together and how they can respond to the priority issue for that sector of the rural population.

It is a model that is not unusual in terms of getting organisations to sit together and plan but it has been unique in terms of having health services work with a range of other organisations outside of a health or community service sector—for example, the agricultural sector—to look at the mental health and social needs of the farming population. It uses an evidence based framework to develop some suicide prevention and early intervention programs. It has also been unique for us because it has been supported and, in some instances, led by groups like the New South Wales Farmers Association. So we see leadership from a key occupational group that can also help overcome some of the attitudinal barriers to seeking help for a mental health problem.

The centre has also been involved in work that looks at the training of health practitioners, not only for mental health practitioners but for health practitioners across the board in responding to mental health emergencies. The common one is the presentation of suicidal ideation and suicidal plans or suicidal behaviour. We have undertaken a range of broad stigma reduction campaigns across rural areas as well as planning ways in which health services can be more accessible to people across rural areas.

I would add that I think one of the big challenges in looking at suicide prevention is not focusing solely on the mental health services; for many people the problem begins well before access to a mental health service. We have a large population of people at high risk of suicide who receive most of their care through the general health sector: general hospitals and general medical outpatient departments. When you look at the evidence around the risk of suicide and people with chronic physical illness, we need to think about service models that increase the capacity of the general health sector to identify and respond effectively to people at risk of suicide. I think the data supports that in terms of the high percentage of people who die by suicide and who have had contact with the general health sector but not with the mental health specialist sector.

Senator ADAMS—It is good to see someone focusing on the rural sector—having been a farmer for many years and being from a small community, I certainly know the problem. The biggest thing is to get someone to actually realise that they have a problem and to access medical services. I am from Western Australia and—as you would be fully aware—rural GPs are a rare commodity. A lot of books are closed, so access is the other problem: where do they go and how do they go? With the men, a lot of the younger farmers now seem to be able to cope because they are so involved with technology; a lot of the older cohort—50 onwards—are very lonely and trying to cope with situations.

Just today, the minister announced that no longer will farmers be propped up, and the interest rate program is to be withdrawn. How is that going to affect New South Wales farmers? I know it has rained, but—

Prof. Kelly—That has not entirely fixed the problem.

Senator ADAMS—there are years of drought behind to catch up.

Prof. Kelly—Yes. Suicide in this sector is a very complex matter. Drought has probably galvanised interest in the mental health needs of farmers, but it would be a mistake to focus on drought alone. There are obviously the other substantial impacts of financial changes, changes in global markets, the changing nature of agriculture itself and the public perception of rural communities and some of the problems that creates—the isolation that people experience. It is a multifactorial problem.

There is some evidence to guide us, though. Some of the work that a colleague of mine, Professor Lyn Fragar, did looking at suicide in farmers illustrated the importance of financial pressure for farmers. And there is some overseas data that indicates that as well—the role of chronic financial strain in increasing the risk of suicidal thoughts. Then, of course, in that context people need to be able to act on that and get help to address that. Anything that can be done to assist those in the farming sector to cope and adapt to the sorts of pressures they are facing is going to be very important. As you say, there may be a difference for some younger farmers, who are approaching the task of farming from a different perspective or with different resources or with a different approach.

One of the things that may be of interest to you is the collaboration with New South Wales farmers. A group of government and non-government organisations, academic groups and health service providers looked at a blueprint for the mental health of farmers. This outlined a series of strategies that could be undertaken by key groups like New South Wales farmers or other farming organisations to bolster the esteem of farmers all the way through to what health services could do so that all the agencies around the table could see that they had a role to play in something like suicide prevention even though they were not necessarily clinical service providers given the broad range of issues that impact upon the well being of communities. That has been a helpful blueprint to start planning some activities and actions that those groups might carry out.

One of the reasons that was done was in response to increasing concerns a couple of years ago about the impact of drought on farmers. A lot of different organisations were saying, ‘We have the solution, we have a service that can be provided, people need to come to our organisation.’ New South Wales farmers quite rightly said, ‘Hang on you probably need to get ourselves sorted out and give us a clear and consistent message about who’s doing what and how we amongst all of this improve an understanding of where people go for help. The GP is, as you were saying, a rare commodity in some communities and access can be difficult but it is very important that any strategies that we put in place include the GP because we need to see suicide as a health problem. The evidence around that is compelling. Mental health conditions that can lead to suicide require careful clinical assessment. It is not that that can only be done by a GP but I think it is important not to exclude the general practice sector from this issue because there may be both physical and psychological problems that need attention by a general practitioner. We have been attempting to work closely with divisions of general practice.

There are other health providers that are a very important part of that web of health services in rural communities such as the community nurses, for example, who are often a critical point of contact but it has been very important for us to work with the sorts of agencies that have day-to-day contact with people in isolated circumstances. They could be, for example, a Department of Primary Industries Drought Support Worker, not a health professional, but someone who is providing a point of contact. It could be a rural financial counsellor, who is not a psychological counsellor but is there talking to people about financial issues. Those financial issues are often the tipping point for people in identifying that they need some help. If you have the person there who is able to confidently say: ‘It might be a good idea if we get you and the family some extra help to cope with these sorts of pressures. What about if I bring along someone I know from the health sector or we organise for you to get to see someone as soon as possible?’ That first step can be critical in identifying where to go for help but also destigmatising that step so that the person with emotional concerns can feel more confident about approaching someone for help.

Senator MOORE—Professor Kelly, can you tell me how the Hunter medical institute fits with the work that you are doing?

Prof. Kelly—There is the Hunter Medical Research Institute.

Senator MOORE—That is the one I mean because they pop up all the time in terms of getting money and doing things in the mental health program.

Prof. Kelly—Yes, there is a Hunter Medical Research Institute and there is also the Hunter Institute of Mental Health.

Senator MOORE—That is too Monty Pythonish for words! I do not know the difference between them. We had a list from the department the other day, which we were thrilled to get, of all the programs that are currently being funded under these areas. I am not sure which one but one of them has been obviously used as a place of choice for the health department to do a whole range of things in the programs.

Prof. Kelly—I suspect that might be the Hunter Institute of Mental Health.

Senator MOORE—Is that linked in with you?

Prof. Kelly—Yes, we work closely with the Hunter institute.

Senator MOORE—I wanted to clarify that because your region around Newcastle seems to have been used a bit in the whole process.

Prof. Kelly—Yes, and they were involved in the Mindframe project and so on.

Senator MOORE—You have piqued my interest now as to why there two places in one region with such similar titles. This whole area of rural mental health is so important and we have identified it in our terms of reference as an area of special consideration. The Farm Link project has been mentioned by the department as one of their key areas and it makes sense when you read it through. I have only seen the overview of it, but it seems to make sense. How much does it cost?

Prof. Kelly—It was funded by a grant from the Department of Health and Ageing under the National Suicide Prevention Strategy initially off the top of my head for around $900,000.

Senator MOORE—Over a period of time?

Prof. Kelly—Over about a three-year period.

Senator MOORE—Has it received ongoing funding?

Prof. Kelly—It has received some additional funding to extend that work. We had an evaluation of the project that indicated—

Senator MOORE—I wish we had.

Prof. Kelly—You have seen the evaluation?

Senator MOORE—No, I have not.

Prof. Kelly—The evaluation indicated the importance of programs having sufficient time to really achieve their objectives. That is particularly important when you are trying to employ people in particular roles. There are so many projects that come and go at short intervals.

Senator MOORE—Which is one of ours and everyone’s major concern—that there does seem to be that. But just in terms of the Farm Link one, that kind of process seemed to be exclusively in New South Wales—

Prof. Kelly—Yes.

Senator MOORE—and the recommendation in your paper was that it could well be rolled out, not just in the farming community but similar models in other areas of specialised need. Has that particular recommendation that you have obviously made through the process, received any feedback from the people that make decisions?

Prof. Kelly—No, not specifically that I am aware of. Certainly informally in discussions the model is one that has appealed in terms of making good use of the resources that are available in many communities. As we indicate, the model of getting agencies with a common interest together to plan access—how they are going to work with high need populations—is important. The other part of it that is important is increasing the sensitivity and responsiveness of the health sector to that population. We highlight in the submission other groups that are important—the rurally based unemployed, for example, who may have very little connection with some of the existing structures that are based on occupation. Given some of the socioeconomic disadvantage in rural areas, I think they are an important group for us to be looking at—and financial issues that have been highlighted.

Senator MOORE—The other group, of which I am particularly fond, is the CWA, who were deeply involved in the FarmLink. So that kind of process.

Prof. Kelly—Yes.

Senator MOORE—There has been an evaluation—

Prof. Kelly—Yes.

Senator MOORE—and we will try and see whether we can get that, and also the recommendation that this model is one that could be translated is something you would like us to take on.

Prof. Kelly—Yes.

Senator MOORE—Thank you.

Senator BOYCE—You mentioned the situation of the financial adviser who might suggest bringing in extra mental health assistance for someone. Does that actually happen? Is it a rarity or is it quite common?

Prof. Kelly—It does happen. In the program of work that I was personally involved in during my five years at the centre there was a great deal of interest in this sort of work from people working in that sector, because they were seeing these problems all the time. There is an interesting national study of the rural financial counsellors that a colleague of mine, Jeffrey Fuller, undertook some time ago that was published looking at how rural financial counsellors perceived their role—the amount of work that they felt might have been mental health related and how that could be addressed. What they said was that they were seeing a lot of mental health related problems and stress in their clients. While there was some interest in increased resources, what they felt was more important was good pathways to care, good backup and advice when it was needed, and some understanding of how local services work. Our Farm Link project showed that, of the non-health agencies—these agricultural agencies, when asked what percentage of the people they see they felt they had a need for some mental health assistance, they said about 30 per cent or more. We had some very good examples in New South Wales where there were terrific partnerships between workers in that sector and health, where they would do what I was describing before: see someone they were concerned about, contact a community psychiatric nurse and say, ‘Would you come out with me to this property next time I go. There is someone I am worried about.’ And they would do that. That was in the south-west of the state and it was working very, very well. What it required—

Prof. Kelly—It is still working well I gather and through this network model we have seen that improve and develop. The evaluation of Farm-Link indicated that through the course of that project there were more connections and networks established between organisations about mental health problems than existed before. It requires us to also focus on the skills of mental health clinicians to understand the importance of that sort of work and to feel comfortable working with people outside the health sector, and it has worked particularly well when those people in health have had an understanding and a familiarity with the pressures facing farmers. Some of them are farmers themselves, so they know what it is about, how to deal with things on the land and how to relate well to people in farming. Part of our project was aiming to build up that sensitivity in the health sector so that, if they see a farmer coming into their clinic, they know what sort of things they might ask and how to make the most of that opportunity, because they may not get that opportunity again.

Senator BOYCE—I have got other questions but I will wait and see if there is time.

Senator FURNER—You quite rightly identified the stigma attached with those remote rural communities. Yesterday we heard evidence of an example of a lack of identification as a result of a patient not being willing to disclose their problems due to the relationships they have in some of those remote areas. I think the reference was about playing golf with a doctor. I have not seen too many golf courses in some of those remote rural centres, nevertheless in those rural centres there is a strong relationship that is built between doctor and patient so I imagine that does happen. I am just wondering what link, if any, Farm-Link would have to trying to eliminate that stigma and build confidence in a person to be more open in those sorts of environments?

Prof. Kelly—A very important component of the Farm-Link project and other projects we have been involved with has been to build an understanding about common mental health problems and confidence in seeking help, not only for oneself but also for others around you—what to do if you are worried about someone, who might be a neighbour or a friend, and how you can help them take the next step. We have also been very keen to involve our health professionals in dealing with some of those issues around complex relationships in rural communities and how to ensure that people get help. The Mental Health First Aid program that we have relied upon for that has been very effective, very well received and highly regarded. Our own evaluations of that in a separate program, the Drought Mental Health Assistance Package in New South Wales that we have been running, has shown that it works well in reducing stigma, building confidence and improving understanding about mental health. That has been a very important strategy.

It has not only been that though. We have worked with Rotary and beyondblue in community forums through our drought project and that has provided an opportunity to increase open discussion about mental health related problems and they have been increasingly well attended through that program. We did a number of them in association with the New South Wales Farmers Association as well with large numbers of people coming to a community forum about mental health and hearing someone who has experienced mental health problems talk about how they handled that and hopefully presenting an optimistic view of what benefits occur from getting help early. People also meet clinicians so they can put a face to a local mental health clinician and see that they are people who can be trusted and relied upon for help. So there have been a number of different ways in which we have attempted to tackle that.

Senator COONAN—At the beginning of your remarks you talked about the multifactorial nature of the causation of particular problems in rural and regional Australia. Is farming an occupational hazard? Is there any one particular driver? Is it just the nature of the occupation and the location and why is it so different to the broader population, or is it not different from the broader population?

Prof. Kelly—I think there are a number of factors. First of all, in rural and the more remote areas we are not seeing the reduction in suicide that we are seeing in other areas, so we know that we have a particular problem outside of our metropolitan areas. There are some subgroups there—farming and men in farming—that we know have a much higher rate than you would expect for the age and general population comparisons. We also know that there is an enormous problem for Aboriginal men and Aboriginal youth in remote areas. That is another area where we have also started to attempt to work. But, yes, there seem to be some particular risks associated with farming. It is untangling what those particular factors are. We know financial pressures are one. This is an international phenomenon as well.

Senator COONAN—Why would that be worse than the general population? I am trying to get a handle on it.

Prof. Kelly—The factors that people have thought about include that farming is often conducted in relative isolation, so a person may be facing these pressures in relatively isolated circumstances. The people that they may be relying upon the most or working with the most may be their immediate family in a family farm, so the opportunities that might exist in other occupations for someone to pick up that you are not doing well, to say something about that to you and to encourage you to get help, as might occur in an organisation, may not work on a family farm. The other issue, of course, is access to means of suicide, with not only firearms but a number of different ways in which people have ready access in isolated circumstances. The problem with isolation is not only that it means that a person may experience less social support, which is important in getting through any difficult period but also that it means there is less opportunity for others to encourage a person to do something about their distress. There is also less opportunity for a person developing pessimism and despair to be challenged by other ways of looking at things or other ways of managing.

We also know that, in general—and I am not suggesting this is necessarily a feature of the farming population, but it is something we have to think about—drug and alcohol problems are very substantial issues in suicide prevention. I have not talked about that so much here, but it is a very important consideration. For men, we know there are higher rates of alcohol misuse and alcohol dependence in the National Survey of Mental Health and Wellbeing than occur in women. Alcohol increases feelings of depression and despair. It increases impulsivity, and impulsivity is a big problem in suicidal men. I think we are seeing a set of ingredients that can come together when a person in an industry and occupation like farming could be at greatest risk.

Senator ADAMS—This is really important. The weather is the biggest problem. Unlike any other business, you have to depend upon the weather.

Senator BOYCE—I was jus thinking about the effect of the global financial crisis on every business. There are lots of unknowns.

Senator ADAMS—That is the underlying thing: you have no control. It is not like the stock market or anything else. You have no control over what is going to happen. This is what worries me about the minister’s statement today—that no longer will that interest be available to farmers. They are not going to prop up farmers who cannot make a go of it. I said you that you might have five years of drought. It has rained, but it is going to take a while to get back. Those people desperately need propping to get there. They have their asset, but it is in the lap of the gods. That is probably the underlying problem.

Senator COONAN—This is very interesting to me because I am new to the inquiry. I came from the bush. It was so rural I had to ride a horse to go to school. I am one of that vanishing breed of people. The resilience of people in the bush is what I remembered of the communities I had been exposed to as a child. It seems now that there has been this national pessimism that I do not remember that has swept over rural and regional Australia. Obviously, if you look at it through a kid’s eyes you see it very differently, but there must have been something that happened in rural and regional Australia that was quite profound to set up this vulnerability.

Prof. Kelly—Yes. The point I was just about to make is along those lines. We need to also look at what is happening in communities to understand the risk at an individual level.

Senator COONAN—Yes; it is broader.

Prof. Kelly—It is broader than that. There are some very resilient communities, but there are also very vulnerable communities. As infrastructure changes across rural areas and some communities get much smaller, there are services that are lost, not only health services but community services, community organisations and volunteer opportunities and linkages. We need to get a better understanding of how that influences the individual level of risk.

Senator COONAN—That is probably very significant. Then again you get the countereffect of sponge communities growing up, which gives much more anonymity to people in tiny communities who are able to go to a bigger centre. It seems to me it is a huge and complex issue. I really do not want to take up your time, but it is very interesting.

Prof. Kelly—One of the things that have come up in some of our work with some communities in rural New South Wales has been a loss of hope. That came from interviewing different sectors of the community about what drought has meant to them. Hope is terribly important for everybody in dealing with adversity. People are questioning the future for their community, for themselves and for their family. Things like the closure of shops in the street and youth moving out of town signify a lot to people.

Senator COONAN—Do you think people do not support each other as much as they used to? Everyone pitches in and helps if somebody has a fire on their place. Whatever happens, it seems to me that there still is community spirit. That is probably one of the things to really tap into.

Prof. Kelly—There is certainly a lot of interest in the aspect of how to promote and build resilience in communities. If communities do well, what are the ingredients to that? You certainly see areas where there is a lot of spirit, involvement and so on. Even in those communities, though, we need to be aware that there may be people who are not connected to those sorts of activities or interests. They may be a bit disenfranchised in those communities—

Senator COONAN—If they have mental health problem perhaps.

Prof. Kelly—Yes.

CHAIR—There are also certain things that one does not talk about. Having lived in a small rural community, I remember there were some things that we all pitched in for but, when it came to certain other things, we just did not. That was their business: ‘If I had it, I wouldn’t want you interfering, and I’m not going to interfere with you.’

Prof. Kelly—Yes. So promoting healthy inclusion in small communities is very important.

CHAIR—The issue I want to get down to is some of the support services. Having lived in a very small country town, I remember we did not have a GP most of the time. We had a nursing post. That was it—one nurse. That was our entire health support service, and the ambo if we needed to get to emergency services. The situation in country towns in WA is not improving on that, and that was sometime ago. It is not improving; it is getting worse. This committee deals a lot with health and allied health services. One of the big issues there is the fact that, even though we do have allied health workers on the ground, they are not in some of the small towns. The connectedness with GPs depends sometimes, quite frankly, on the particular GP in the country town, if we have managed to get funding and actually find somebody. While I absolutely support and agree with what you are saying, I am a bit pessimistic about how it is actually operating out there. New South Wales is probably different to some of the other states, but in WA I certainly do not see a lot. I am not panning some of the good work that is occurring, but the support we have on the ground is so small.

Prof. Kelly—I agree and I think that there are difficulties like that everywhere. It can be quite fragile. It can work well for a period; one person leaves—

CHAIR—That is exactly right. Quite often a particular person is the linchpin making things work. They go and you have lost it.

Prof. Kelly—From our experience that is why it is very important to have a very senior organisational leadership in what is done. While that leadership supports local solutions, it backs them up for sustainability. Sustainability of rural services is an issue that concerns a lot of people. Trying to find service models that will work in resource-poor environments, effective use of internet technology, for example—

CHAIR—My next question was going to be about the use of internet technology. How is that going?

Prof. Kelly—As I understand it, the evidence from groups like MoodGYM and others—at the Australian National University, they are really leading a lot of the internet based interventions in Australia—has been that there has been an enthusiastic take-up of those services across rural areas because they are accessible and also, perhaps, because there is a degree of anonymity in these. I think we need to see them as part of a suite of options rather than relying on them entirely as the alternative to the usual health care. But people have, in our experience, been using the internet well to get information.

I think that beyondblue and the resources they provide have been excellent in reducing stigma, from my experience, linked with some of the things that Rotary have been doing across rural Australia. They have been looking at a number of the ways in which a very positive image of mental health can be presented. Everywhere you go, people talk about what beyondblue have done; they have a very recognisable brand.

There are practical issues, of course, in terms of reliable access to the internet and the speed of access, which sometimes limit what you can do. But, if we think about the farming sector, they are often very equipped to deal with the internet every day, looking at the weather, following markets and so on, so perhaps there is room for us to move in using that much more effectively for increasing community knowledge, understanding and access to treatments. We have also been using it as a tool for training health clinicians around mental health so that we can increase access to good information and training resources for them. That is something we need to look at as well, because those clinicians you are describing, while they might be small in number, have their own professional development and support needs that we need to recognise.

CHAIR—We are just on time. We have a very packed day, I have to say. Thank you very much for both your submission and your time. We very much appreciate it.

Prof. Kelly—Not at all. Thank you.

CHAIR—As you can tell, there is a great deal of interest in these issues. Thank you.

Proceedings suspended from 10.22 am to 10.42 am

GARNER, Reverend Dr Keith Vincent, Superintendent/Chief Executive Officer, Wesley Mission

MAYSON, Ms Penelope Jane, Operations Manager, Suicide Prevention Services, Wesley Mission

CHAIR—Welcome. Is there anything you would like to add about the capacity in which you appear?

Ms Mayson—I oversee the services of Lifeline Sydney and Sutherland and Wesley LifeForce.

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

Rev. Dr Garner—Yes.

CHAIR—Thank you. We have your submission. Thank you very much. I would like to invite either or both of you to make an opening statement and then we will ask you some questions.

Rev. Dr Garner—I propose to make a statement and then perhaps we will both engage in the questions.

CHAIR—Okay.

Rev. Dr Garner—Thank you for the invitation to participate in the hearing. Wesley Mission have been addressing the issue of suicide for many years. Our work is across a broad spectrum of welfare services, which means that we care for clients and patients who are at a high risk of suicide. We see this in our aged care, our homeless work and in psychiatric hospitals. As noted in our submission, Wesley Mission under one of my predecessors, Alan Walker, gave birth to Lifeline in 1963.

We established another leading suicide prevention service in 1995, Wesley LifeForce. LifeForce is a national suicide prevention program that develops and delivers educational programs in communities to help people look at wellbeing and all those other issues that are significant and important in that area and to deal with the issues of potential and actual suicide. Working collaboratively with organisations and local communities, LifeForce has developed strategies to raise awareness of suicide and mental health issues in those communities. It is the principal source of mental health information for many groups, especially in rural and remote areas. LifeForce also works collaboratively with key organisations in the mental health sector and undertakes ongoing research to identify the best resources and strategies for suicide prevention. These are strategies and activities that focus on training community members from all walks of life to know what to do confidently and appropriately in times of suicidal crisis.

Since 2007, LifeForce has also developed community suicide prevention networks or what we call ‘community coalitions’. A network or coalition is a union of people—organisations from the voluntary sector and other areas—working in voluntary collaboration to influence outcomes on a specific problem within that community. The specific aim of this project has been to develop within each targeted community localised suicide prevention objectives. These include identifying and bringing together key members of the community with a concern or interest in service provision in suicide prevention and mental health. For example, they might be key community leaders in business, education, religion, the criminal justice system, the media and health—a wide variety of people. They may also include parents and youth in the community rather than just organisations. These members facilitate the exchange of information. They coordinate their suicide awareness and prevention activities, thereby minimising the duplication of services which we see as one of the issues.

The Australian government’s National Suicide Prevention Strategy has, as its goals, as you will be well aware, to reduce death by suicide and reduce suicidal behaviour, by adopting a whole-of-community approach, and that is something that we endorse and believe to be very important. This whole-of-community approach is admirably demonstrated in the network’s project. There is something wonderful about the connectedness within the community, especially when one contrasts it with the tragic sense of isolation that we are actually dealing with. So the very way in which we go about this actually has a message within it that speaks to the difficulties of isolation, which is clearly linked to some aspects of and underscores the pain of suicide.

LifeForce is the lead agency in the initial stages of establishing a network. However, our service seeks to empower the local people in the community by supporting the network to a point where it is able to act independently and in a way that is real. Since 2007, LifeForce has established 11 networks, including an Indigenous suicide prevention network in Dubbo in New South Wales. Our sincere hope is that local communities establish suicide prevention networks in every state and territory across Australia.

When considering our contribution to the inquiry, we had to ask ourselves, ‘What is it that we can say and offer?’ We believed it would be good to consult and talk with those who we work alongside, where we are a leading provider. So we did a modest survey, of which you see a little bit in the report, by talking to people and inviting them to give us some feedback, structured around the inquiry’s major headings. We received 42 responses from people who were working with us, within a two-week period, so there was a great interest in making a contribution to what it is that we are doing today. We have summarised our findings and recommendations in relation to that. You have the full report before you, so I do not want to go into every detail of that but just to highlight a few of the issues.

Firstly, with regard to the personal, social and financial costs of suicide in Australia: clearly the cost of suicide is very great. The bereaved are very heavily impacted upon. There is the extreme emotional pain and grief; the extreme risk of suicide to close family and friends; the consequential mental illness, depression and anxiety issues; the relational breakdown in family and social networks that emerges; and the financial hardship through loss of income, and the cost of finding support.

There is also a great cost for carers and service providers providing help to those at risk. Community services staff report high costs associated with responding to a person who presents themselves with a need in this particular area—a person at risk. These costs relate to the additional time required to be given—and it is something that you cannot be time-mean about because of the very nature of what it is that we are talking about. There are also the emotional impact and the potential longer term costs: employee assistance programs, workers compensation—all the things that do not appear generally when you talk about this issue but which are in fact costs that have to be thought about.

From Wesley Mission's perspective, it is agreed that there are identified service gaps in the care of those bereaved by suicide. There is an increasing demand for suicide bereavement groups. For example, we support the expansion of services such as the stand-by response service, of crisis response to people who are bereaved. Wesley Mission believes a great deal of good can be done for a reasonably small cost. The danger would be in people like ourselves appearing before you and saying, 'The answer is to just throw money at these issues.' We think a lot can be achieved, at a reasonable cost, in terms of helping people, establishing groups, and helping families, children and those at risk of suicide, in groups that are creative and helpful. A little money can actually go a long way. There is a need to bolster supervision and to support community service and hospital staff—those who deal with high risk people.

Another area to highlight is training. This is a major area for our LifeForce area, and you will notice that we put Lifeline and LifeForce under the same banner of suicide prevention services because we see the two as having a relationship. There is a great need for health and community workers to be equipped to apply suicide intervention skills, but it is essential also for the general community. Wesley LifeForce is experiencing great demand for the training that we offer. We simply cannot meet that demand. Our mental health training group was inundated with interest in the Assist program, which we are offering in Darwin this month. We are doing this across Australia. As soon as we start to offer it many more people want it. That is the reality. And we just cannot do that; there is a limit to what we can do. So there is clearly a need for greater availability of community and professional training. We need to understand that suicide, as has been said quite clearly in government directions on this, is a whole-of-community issue. It is not just an issue for organisations like us, or for government; it is for every area of the Australian community. We could talk about statistics all day long but the reality is that we think a joint way of finding the solution will be the most helpful. That is the area that we feel strongly about—a whole-of-community issue and a whole-of-community response. We are happy to talk further about that.

CHAIR—Ms Mayson, would you like to add anything?

Ms Mayson—I would like to highlight that, for example, across a broad range of Wesley Mission services suicide is an emerging and recurrent issue. Sadly, suicide is a reality in the supported accommodation services, for example—giving people the care that they need.

Senator MOORE—The LifeForce program is one of the programs listed by the department as one of its key national programs. We have asked them to give us some more information about it. But can you give me any idea of the funding base and the funding nature of LifeForce? If what it plans to do is done, it would respond to many of the issues that people have raised in the submissions. It is a focus of your submission as well. Can we get some idea of the funding, and the timeframe for the funding? Is it recurrent? We do not have any idea from the department whether you are funded into the future or for how long. It is such a massive program. Also, what is the evaluation process? It is such an impressive program in the way it has been presented. By the way, we know how far reaching your network is. I would really like to get some more understanding of how you are interacting with the government on that.

Rev. Dr Garner—It is not there forever. Do you want to say something about the funding?

Ms Mayson—It is funded by the Department of Health and Ageing. I would love to say that the promise is there way into the future. Of course, the reality is that we are funded for two major projects—networks and training—for a period of two or three years at a time.

Senator MOORE—For how long? In your submission it says you have been doing it since 1995.

Rev. Dr Garner—We can look with some certainty into the future for about two years. It is not a constant stream of money. We keep coming back.

Senator MOORE—It is not recurrent funding?

Rev. Dr Garner—No, and both the last government and this government have been part of that development. We can see the way for two years. That is quite good for us.

Senator MOORE—We fought very hard in this committee to get it from one year to three. We have a goal to go higher than that. The ridiculous nature of single-year funding made it impossible for any organisation. Maybe I will put this question on notice so we are not wasting time. Can we get the details from your perspective?

Rev. Dr Garner—Sure. I can get them to you very quickly.

Senator Moore—That would be great. Also, I am very interested, for such a wide ranging program, in what your evaluation strategy is. I understand that the funding now comes with an expectation that you develop and have a transparent evaluation mechanism.

Rev. Dr Garner—We built that more and more into all our programs across the mission, that we be open about every area of it and that it is actually very good for our people to become the normative—that you always say: ‘How do we look at the effectiveness, delivery, cost, all of that.? We run a program to do that all the time. This is just part of all of that natural atmospheric—

Senator MOORE—And by nature of your business you actually have the size to be able to have a look at that, and that is your business plan.

Rev. Dr Garner—Yes. We know we are a broad organisation, so we are involved in a lot of welfare agencies. We did not narrow things down to just one focus. For example, to just take Lifeline, as Penny has said, we look after Sydney city and the Sutherland Shire. To actually underpin that work we put in $300,000 as a mission to maintain that. We could not even deliver that if we did not put money into it, because we train something like 150 people every year. It is what is considered to be a very, very highly trained group. But it is constantly necessary to leverage off the broad organisation. This is one of the areas—this is not *Hansard* language—that never pays its way and never could, because we are dealing with the caring of people and we do not measure it in that way, so, financially, we have to leverage off the rest of the organisation in order to do it.

Senator BOYCE—When you put in that information, could you give us the locations where the program is being or has been delivered and things like that, please? I am sorry; is that one of the appendixes that I did not get printed out?

Rev. Dr Garner—It gives you some of them. For example, in Tasmania we are having a LifeForce event in April. We are developing a program in Tasmania. But there is a list of some, to give you an idea.

Senator MOORE—Where you are doing this you have a pre-existing network, so you are not coming in cold?

Rev. Dr Garner—We have a network, because clearly Wesley Mission has its history. It has its relationship with the Uniting Church and its links with the community, so we never come in as a complete outsider to do this; we have those friendships. We basically work on the network principle. We take the view that our job might be to be the lead agency but not be to be there forever as the ones driving it. We want to release it so that local people take accountability for and control of their own work. I think that is critical to how you lead it and why people get on board with us.

Ms Mayson—We will continue to support administratively the networks in any way we can but, yes, it is about empowering the local community. If I can just take a step back: we always make contact with the agencies within a particular area, often in centres such as Anglicare or Lifeline, or members of local government or mental health services. We find that, almost invariably, we are very welcomed with that approach.

Senator MOORE—So the way it has been described by the department—and I would imagine that the dot points they provide to us come straight out of the contract—is: identification and establishment of suicide prevention networks in all states and territories across Australia. I take the point about identifying it, which is getting people together. You made a point there about providing administrative support, so I would think that would come under the establishment. So the expectation in the contract is that Wesley will actually become the organisation that pulls these networks together. So it is not just an audit; it is much more than that which is actually making them an active part of all states and territories—is that right?

Ms Mayson—Yes, that is correct.

Senator MOORE—Now help me out in terms of a state like Queensland—I am showing my absolute parochial bias.

Senator BOYCE—And what could be wrong with that?

Senator MOORE—I think it is perfectly understandable—there are two Queenslanders who share with me this committee. It just happens that we are Western Australians and Queenslanders. Senator Coonan was here this morning, so we have a touch of New South Wales.

In a state like Queensland is there an expectation that there will be one network or that there will be a series of networks? I cannot tell from what we have in the notes.

Ms Mayson—It really relates to capacity. We would like numerous networks, not simply for the sake of having networks, of course, but strategically to work in rural and remote areas with a particular focus on the Indigenous communities. The issue is around capacity and what we are able to provide in terms of it. So for this next project we are planning to develop a further 10 networks—several in Tasmania. As we have mentioned, we would like to venture into other states and territories.

Senator MOORE—It gives me hope. If you have said there are several in Tasmania, that should indicate that Queensland should have a lot more, I would have thought.

Ms Mayson—Absolutely, that is our hope and intention.

Rev. Dr Garner—And which Queensland? We realise it is very different in Brisbane than it would be in Rockhampton or that it would be in Noosa or wherever.

Senator MOORE—So is that spelt out in the contract, Rev. Garner? When you read the dot points we have been told about, it is identification and establishment of suicide prevention networks in all states and territories across Australia. So when you get something as wide as that, how is it negotiated? Is there an expectation from the department—and I will be asking them this question as well; I have just made a note to myself—about your working with that? Does the department say, ‘We expect to fulfil this, at least one in every state and territory’? Or do they say, ‘We would like to have this number,’ and then you work with them to deliver it? Or do you determine, because of capacity, ‘This is what we are able to do’?

Rev. Dr Garner—I think it is your latter answer, but with a bit more sharpness than that in the sense that if you were doing an audit of our performance, as it were, you would say, ‘Where are we now from where we’ve been?’ And we would want to be constantly moving towards that goal, which I agree is a little open-ended in its saying ‘everywhere’. But within the capacity of the amount of money that is given, it would be difficult to hammer it down to so many. We certainly want to achieve that and in our strategic conversations within Wesley Mission, and particularly within Penny’s area, I would be constantly asking them, through our whole mental health community and counselling services, to say, ‘Where are we in terms of achieving some of those goals, and can we give an answer to that question—that is, that we are moving towards them?’

Senator MOORE—Can we get some information—whatever you are prepared to give us. You have talked about it in your submission, amidst everything else, but I have to admit a certain focus on this in my own mind because I am trying to look at what the plan is saying that the department is saying they are doing. But if we could get as much as we could from Wesley’s perspective about where you are now, 12 months into the program, where you are hoping to move in the near future, and also the evaluation process for that then that would be really great. We know how much work you do in this area, so I hope you do not feel as though I am being too intrusive, but it is to get on record such a major process of where we are going.

Senator BOYCE—One of your comments is that the National Suicide Prevention Strategy has a very low profile and very few people know about it. Why is this an issue?

Rev. Dr Garner—It is an issue in terms of going into a community to build a network. If it has a profile it makes it easier to talk with people who may not naturally be part of a coalition of goodwill, but could easily become part of a coalition of goodwill.

Senator BOYCE—So otherwise they are perhaps thinking: ‘Why did they pick us? What have we done?’

Rev. Dr Garner—So we think by raising the normative profile of this issue, it is not really a case of advertising our services, but making it possible for people to become a part of it and seeing that they can make a difference. It is more at that level than it is promotion of our services. We use all the strap lines you would imagine, like more people die of suicide than they do on the road, and we have to start at that point because for a lot of people they are not aware—

Senator BOYCE—It is still not a very well-known fact.

Ms Mayson—No, I agree.

Rev. Dr Garner—And the investment: $30 million to $40 million directly on suicide prevention; $4 billion on road safety. I am not denigrating road safety at all, but I am saying we have to sometimes begin with anecdotal information to get people on board. The more there is awareness of the issue, the better it is, but for only the good reasons, not to leverage off it painful facts for people who are already grieving. Also, it helps our people to realise when they are helping folks, and for folks who are being helped to realise that they are not alone in this. It is a big issue. In fact, suicide is the No. 1 cause of death for men and women under the age of 35. When you say that, people say, ‘Really?’ Yes.

Senator BOYCE—Ms Mayson, you particularly mentioned the issue of suicide in supported accommodation. Could you tell us a little bit more about that issue?

Ms Mayson—Probably the expert in this area is Rev. Keith Garner. However, I can certainly—

Senator BOYCE—You will both say something.

Rev. Dr Garner—We really are doing a lot of work in the homeless space. One of the things that we do when we prepare a paper like this is to talk to the guys in the area. I will just give you an example: I always receive information about this, but we have at least three deaths by suicide in our homeless centres.

Senator BOYCE—In Sydney?

Rev. Dr Garner—Yes, in Sydney. So that gives you an insight into that context. It is interesting that while we have been preparing this paper, I have been dealing with one of them again. And very often they are people who are isolated, they do not have the support, so we try to draw in lots of our support, but it is a traumatic experience for everybody concerned, and we have emergency responses as to what to do for staff, for volunteers, for clients, for people who are sharing the accommodation et cetera. So it is something that we see, but it is across lots of different areas, isn't it?

Ms Mayson—Yes, and also the time and cost of appropriately supporting those at risk within those services.

CHAIR—And I would have thought identifying those at risk because it is already a high-risk group.

Ms Mayson—Yes, even identifying and ensuring that front-line workers are able to identify. So we have been providing LifeForce training throughout 2009 at Wesley Mission to employees of Wesley Mission who are front-line workers.

Senator BOYCE—But one would expect that that would be one of the highest risk groups of all. I just wanted to follow-up on that a bit more.

Senator FURNER—Wesley Private Hospital has a mental health facility, and one of the things that has been identified during the inquiry is the critical need for post release in terms of patients. I am wondering how the unit deals with those particular issues associated with patients that are released.

Rev. Dr Garner—It is a major issue for us when people go into the community, isn't it?

Ms Mayson—Yes. It is an area that we would like to develop, particularly following people exiting the hospital and providing a follow-up service. We are currently discussing how we might best do that. There is some limited follow-up, but we would like to develop that further. Particularly identifying, again, those at risk.

Senator FURNER—So at present there is no process that you have in place where there is ongoing support after the release from hospital?

Ms Mayson—Yes, it is informal.

Rev. Dr Garner—The word 'informal' is the word I would use. The answer is that I would be reluctant to say there is none, because we are an organisation that would always try to do something, but there is none structured in the way that you can run these services. So whatever we do is over and above what we provide, and we do that when we have identified particular risks as opposed to as a general rule.

Senator FURNER—You identified Dubbo as being the centre for Indigenous assistance for suicide out there. Is that correct?

Ms Mayson—Yes.

Rev. Dr Garner—Yes, that is the Wambool Aboriginal Suicide Prevention Program.

Senator FURNER—Can you elaborate on what sorts of programs you have, and successes, in that particular location?

Rev. Dr Garner—It is a good one.

Ms Mayson—Yes. It has been a very interesting network in that there has been particular work with key leaders within that Aboriginal community contact and decision making occurs from the bottom-up rather than from the lead agency. We want to be culturally sensitive and aware. The progress in establishing that network was slower, interestingly, but it has been a wonderful learning experience for us. Out of that experience, the LifeForce team members who work in networks and in training are attending cultural awareness training tomorrow, in fact, at Wesley Mission by a very proud Murri who is a leader in that. It has been a terrific example of working collaboratively with members of the Indigenous community, who have been very open in their praise to our staff members. So hopefully we are making the right approaches there. It seems to be working.

Senator ADAMS—In the rural areas, as far as the program goes, how do you start up a new program? Could you give us an idea of who you contact and what partnerships are brought into it?

Ms Mayson—Yes, certainly. Sometimes it can be an initial contact—people such as members of the public contacting LifeForce and asking for assistance by way of training. Often there is a training link or introduction to the establishment of a network. We also look at the statistics around suicide in rural and remote areas—right across Australia, really—and we are examining that at the same time and incorporating that into our planning of where a network will be. So we often use training as a leverage point. We will often contact a local Lifeline centre as a starting point, or we may be contacted by local members of government who are concerned about the issue in their area and will make contact with our organisation that way.

Senator ADAMS—Do you work with local government?

Rev. Dr Garner—Where we can, yes. It depends on the area.

Senator ADAMS—Yes.

Rev. Dr Garner—There is more energy from some local government people than from others. But, wherever that is possible, we think it is very important that they do that and that they are seen alongside us. We have been very clear that, when we work with networks of people, what matters more is from below up rather than too much top-down. So working with political or governmental people has to be done sensitively. But we do try to do that, yes.

Senator ADAMS—The reason I am asking is that local government is made up of people from the community.

Rev. Dr Garner—Sure.

Senator ADAMS—Therefore they are community leaders.

Ms Mayson—Absolutely.

Senator ADAMS—I was just wondering exactly what—

Rev. Dr Garner—That counts more in a rural area than it does anywhere else, because they really are key figures in the sense that they are senior in those communities. So we would do that as a matter of course.

Senator ADAMS—If there were a cluster of suicides in a rural community, would you proactively go and talk to people in that community or would you wait for them to come to you?

Rev. Dr Garner—We would have to be sure that we were not going into a community uninvited; that is really where you have to get the sensitivity right. But we usually find that, if there is a cluster of suicides, that might actually happen naturally through one of the ways Penny has described—somebody in touch with us for one of the many reasons they might get in touch with Wesley Mission, or because somebody says they know a little bit about it but do not know much. That gives us a door, but it is very difficult to walk into a situation uninvited, and we really have to get that right. That is one of the things we have really learnt from managing to do something in the Dubbo area that was described a few moments ago. It is particularly important there that we come in with sensitivity and do not drive our way in and say, ‘We’re the guys that know all the answers to this,’ because in reality there can be some very particular reasons why suicide in an area is particularly high, and we want to be responsive to that and not just come with a kind of panacea to say, ‘Here’s the map.’ It is a bit like the whole bereavement thing, when you are dealing with people who have died. You may have a pattern of things like shock, anger and all the things that happen, but they do not happen in that order. To come in with something as a blueprint is a dangerous thing, so we try to be responsive to those targets of going everywhere but with an invitational sense to it too.

Senator MOORE—In terms of process, Senator Adams was talking about going in, but what happens if there is already a pre-existing network there? We had evidence yesterday in Queensland, and the Cairns region presented evidence of what to me sounds like an extremely effective, vibrant pre-existing network. Part of this process with Life Thing—I am sorry; all of them sound—

Ms Mayson—Is that on the record?

Senator MOORE—It will be, yes.

Ms Mayson—That is okay.

Senator MOORE—All of these things have very similar titles. It is one of the more confusing elements: that all of them are variations on—

Ms Mayson—I am sure.

Senator MOORE—But, in terms of the process, when you are developing this network of existing networks about suicide across the country and you become aware of one that is there and active, what is your role?

Ms Mayson—One of the key messages here is around communication; we communicate very well, I believe, with other service providers. The issue of suicide in Australia is huge. I celebrate networks already established. I like to be generous, and I know that our teams do, in relation to them. That is great. Do they need our support in any way? Can we offer anything? We may be able to collaborate. Otherwise we certainly would not barge into an area where there are already very well established networks, training, suicide prevention activities and so on and so forth.

CHAIR—So you would do a gap analysis?

Ms Mayson—Yes.

Rev. Dr Garner—The country is so big and the needs are so great that we believe there will be enough to keep us going for many years, without having to worry about stepping on each other’s toes.

Senator BILYK—In your submission you mention that a lot of local coroners face influence from families to make a finding other than suicide. On reading that I thought that is probably related to the stigma that is, unfortunately, attached to suicide. Can you elaborate on that a bit more? Are there any facts and figures for that or is it just part of the overall reporting program that coroners have to go through in how they might report things? Can you expand on that comment for me?

Ms Mayson—We did have some comments on that from some of the 42 respondents. I do not have other figures, but it certainly compliments the larger picture that has been painted around the stigma associated with suicide. The personal comments relate to that stigma and the difficulty of families facing that and perhaps the shame associated with suicide.

Senator BILYK—So they would rather that the coroner did not record it as a suicide?

Ms Mayson—That is correct.

Rev. Dr Garner—It adds to the burden of grief that would normally go with the death.

Ms Mayson—It could be a terrible accident rather than a suicide. That is the reality that we face.

Senator BILYK—But do coroners actually do that?

Ms Mayson—We would like to think not.

Rev. Dr Garner—On an occasion like this we say we have no evidence that they do, but the very fact that people raised that in the headlines you have given in response to our survey tells us—and the survey is just not a carte blanche; it is for people were are working in partnership with. Maybe it is not just guilt and stigma; maybe it is shame—that is probably a better word really—that surrounds it for families. They find it very hard to deal with. The more we can be involved in training and the more we can address the question of guilt, shame and stigma in all its different guises, the more chance we have of making sure that that is not a comment that people will make five years from now when they talk about it.

Senator BILYK—I presume for a lot of people there is still the religious stigma associated with it. I do not know what the case is now, but I know that previously there could not be a funeral if the family member had committed suicide.

Rev. Dr Garner—That was true I think in most of the major religions that are representing in Australia, Christian and otherwise. The issue of suicide has become so real that you cannot hold to that kind of perspective in that kind of narrow way much longer. There has been a greater maturity in handling it really.

Senator BILYK—So you think that has moved forward?

Rev. Dr Garner—It may still exist in some people's minds, but religions respond to people in need and the ground has shifted enormously and those who have the ability to reflect about these things in a philosophical way have had to move. It is an outrageous thought that somebody should feel that somehow there is even a religious dimension to this. It might be cultural in the broader sense—that is maybe what it is as much as religious—because the reasons for doing it sometimes are not underpinned by strong religious reasons but belong to a transported pervading culture that exists within.

Senator BOYCE—But surely the fact that it was a sin in the view of the Church—in the church values so to speak—must be part of the reason why people still have that view.

CHAIR—We are over time. Perhaps you can take that on notice rather than start down a whole new avenue of discussion, which unfortunately we do not have time for. Thank you very much for both your submission and your time. It was very much appreciated. We could keep talking to you all day, let alone to all the other witnesses as well.

Rev. Dr Garner—We look forward to supplying you with some of the information that you asked for.

CHAIR—That will be very much appreciated.

[11.20 am]

CAMPBELL, Dr Andrew, Chair, Richmond Fellowship of NSW

RUTLEDGE, Ms Pamela Rutledge, CEO, Richmond Fellowship of NSW

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

Dr Campbell—Yes.

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

Ms Rutledge—Thank you very much for the opportunity. We greatly appreciate it. We want to limit our opening remarks to allow you time for questions. Just very briefly, Richmond Fellowship of NSW is one of a number of not-for-profit organisations working in the field of community based mental health, supported accommodation and psychosocial support for people experiencing a disability arising from a mental illness. Many of the people that we work with are at risk of suicide in association with their illness. Our organisation is one of a network around Australia, and we do have the capacity to operate at both state and the national level. We receive funding from both the state and Commonwealth governments and we would reinforce those comments that have been made about the importance of triennial funding. We also would emphasise the need for funding to include some capacity for evaluation. We are very committed to evaluating the work we do, to demonstrate its results and to learn how it can be done better. At the moment, we are funding some of that evaluation ourselves because in most cases there is no capacity within the funding we receive—project by project—to evaluate it. I think that is a great lack.

Our submission points to several areas where we believe we have evidence of working effectively as part of a continuum of care with the health services and in partnership with Housing and other providers on the ground. We are able to build that coordinated care model with other agencies and we are able to cross the silos that work in the community. At the front end, we believe that there is great opportunity to work effectively in this area and we point to areas where we believe there is great value in looking for growth around programs such as our young people’s program, our young people’s outreach program, our work with women with a mental illness and their children, our work in Aboriginal communities—both in Sydney and in the western parts of the state—and our beginning work with rural families.

CHAIR—Dr Campbell?

Dr Campbell—Thank you. I am here as Chair of the Richmond Fellowship. The board tries to set a strategic direction for the organisation. I also wear a lot of other hats. I am still an active clinician and work out in the rural far west of New South Wales. I have to put the rubber on the road, if you like. These programs only work if you have people out there doing it. There are a number of issues that come out of that not directly from the work we do at the Richmond

Fellowship, although I have tried to steer us in the direction of working out in the bush and working with different communities at risk. I thoroughly endorse everything you have heard this morning. I think there was very good information and there were pertinent questions.

There were a couple of things I thought I might focus on. One is the role of targeted programs and services addressing the particular circumstances of high-risk groups, including the prison population. We do not as yet provide a programmed support service to people coming out of jail, but we think that is an important direction that we should travel in.

As a clinician, I have had the privilege of working out in Indigenous communities. We can learn a lot from some of their solutions, particularly to suicide. There is a prison which is 30 kilometres out of Brewarrina which has no walls. It was set up as a result of the deaths in custody inquiry, so it is a direct result of inquiries into suicide. That is the Yetta Dhinnakkal prison. It basically operates as a stock standard custodial service. They fly in the custodial officers every two weeks, they stay and then they fly back to Sydney. It is the standard custodial service you would get in any prison. But what they did as a result of the inquiry was put in two nurses, Nurse 1 and Nurse 2—because they are not necessarily distinguished by the inmate population—who do a wonderful job of assessing, supporting and helping people in the initial phases.

Senator BOYCE—They are mental health nurses?

Dr Campbell—No, they are generalist trained. There is only one mental health nurse out in the area I work in, snatched by the community services. They are generalist trained but they have a lot of savvy and experience. They both come from farms and farming experience—which I am interested to see is the experience of a lot of the senators—so they are very practical people and they have good empathy. The prisoners are basically people who have merited a sentence of six months or more—which is one of the reasons that the prison works—so they have time to work with people. They sort them out. They get a GP who visits and looks at their physical health. They get a dental check-up once they have settled down, and they go off and get their teeth attended to. If there are any identified problems, I get called in to assess what is going on. Quite a few of them have brief psychotic episodes when they hit the jail. Partly, they are coming off the drugs, and partly it is just the stress of being away from home and what has happened.

The second injection into that prison is the TAFE: two TAFE teachers who do certificate courses. Once people have come off their psychosis, got their medication sorted and got their teeth fixed, they then have time to start work on the vocational stuff, which is crucial. They are all doing certificates. At the end of it, most of them do not want to leave if their time for custodial service is up: ‘Can I just stay and finish the certificate course please?’ Unfortunately our prison systems and custodial services do not work that way.

I think it is a wonderful model that works very well, and I see very good results. The other thing that TAFE do that custodial services do not is that they are very interested in what happens to their people, so they have an active follow-up program, so they can track people 12 months down the track after their release to see what is happening. Most of them have got jobs, which I do not think we can do in our normal, standard services. I think that is an interesting model, which I came across by accident, and I have seen it work very, very well.

Senator BOYCE—What is it called again? Yetta?

Dr Campbell—It is a long Aboriginal word, but Yetta is the other one. Recently, they had a freak wind that blew it down because it is all little dongas and it is out in the flat desert country, so the program had to stop for a while. But, fortunately, a lot of the prisoners who were due for release then had jobs rebuilding it, so they stayed on.

Senator BOYCE—All those certificates came in handy!

Dr Campbell—And the timing! I just thought I would raise that because that is a target group that we could do a lot more with, and I think there would be another role for the Richmond Fellowship in picking up people who come out of the prison system and easing them through that initial phase. There would be a range of things. Often, if it is accommodation they need then that could be house based, or if they have somewhere to go it could be home based. That would be something that I think we should develop as an organisation, but obviously funding and the model need to be set up and established.

The other thing I have learnt about from working out in the bush is something that came up earlier, the recruitment and retention of skilled people. It almost happens by accident; there is no policy around who they get, but we had a very good generalist nurse who converted to mental health. She really did not know much about mental health but she was keen to learn and had a lot of practical skills. The important thing that she did not know was that you could not get a community together and talk about things, so she organised a community meeting. It was largely around—

Senator BOYCE—No funding!

Dr Campbell—No, there was. I do not know how we got the funding. It was just a barbecue. A local farmer provided the venue and the meat came from somewhere else. But a third of the women in the whole area got together. I was astounded at that. If I tried to do that in Sydney, I might get three people and their dog turning up. So there are wonderful things that can happen out there that we can learn about. The issues were mental health and healthy responses to stress in the farming community and particularly about retirement—how you get off the farm, because it is not easy. That happened, but my concern is that, since she left, it will not happen again.

There is no requirement on anyone running services out there that one of the ways we know you are running a good service is that you do have community involvement at least once a year, or how do you go about all of this? It largely comes out of the general GP services attachments there rather than mental health. I think we should be making more requirements on directors of service to provide actual community involvement outcomes; it is not just the number of people you see at a clinic, which is how they measure what I do. So I did not get any brownie points for going to this meeting and meeting up with people, but everyone knew I was a shrink in town and they could come and see me and I seemed to be a friendly face. It had a lot of impact, I think.

The other thing you should probably draw your attention to is the Trieste model in Italy. Are you familiar with Trieste?

Senator MOORE—Senator Allison, when she was here, made sure that we all knew about Trieste.

Dr Campbell—I do not need to emphasise that then. I have not been there myself, but a lot of my friends have and swear by it. That is again about community involvement and the whole attitude of the community. They have got away from the silo model. They have very much a vocational model as well. They know people have recovered.

Our job is to help people with mental illness on the road to recovery, but it sort of stops when you get a job. We have very poor success at getting people into mainstream employment. We can put people into sheltered employment. We can do a lot of things, but mainstream employment is still beyond the grasp of our mental health services.

One of my hats is running a themes conference, which we have been doing for 20 years. Last week I was asking, ‘What happens to your PBS funding after you have got a job?’ because medication is a big part of helping people with psychotic illnesses get better, and they are now treated with the high-cost drugs, not the low-cost drugs. When I was a young psychiatrist, Largactil cost a couple of cents a pill. Now it is many dollars. Each pill is worth its weight in gold. That pricing is largely determined by their utility; it is nothing to do with the costs of manufacture. You could spend hundreds of dollars a week staying on your medication. If you get a job, how long does your PBS last? Two years, then you are off. So you have to get sick again to get care.

I think there are structural problems in the way we see recovery. This particularly applies—and thank goodness for Pat McGorry—to the special group of young people who have developmental illness. We need to have different rules for managing that. Most of us, when we get as old as me, can afford to buy those expensive drugs, but for that young group I think we need to have special rules so that people can get better, get a job and recover—they still have their illness but they are coping with it—but not be pulled off their medication or financially imperilled. That is something that I think we need to look at at a federal level; it cannot be solved by the states.

CHAIR—We will run out of time, so not everyone will get a go on this one. I am just warning people. Who has a burning question?

Senator FURNER—Your submission refers to—in the attachments—a number of examples of people who have attempted suicide. This is an area we have not focused on yet. There was a young man, aged 17, who exhibited symptoms of psychosis. It appears to be directly linked to the use of cannabis and alcohol. When it was brought to my attention I did some research on the net and found that the New South Wales Department of Education and Training has a paper on mental health and adolescent cannabis use. It indicates that 16 per cent of those admitted to hospital for serious suicide attempts had been users of cannabis compared to two per cent of non-users. In your experience, did you identify any parallels?

Dr Campbell—Senator, you have me on my hobby horse.

CHAIR—Don’t stay on for too long! That is a gentle warning because we will run out of time.

Dr Campbell—John McGrath in Queensland last week put out a paper showing there is a times four increase in the rate of psychosis in regular cannabis users. We know it is something that happens to adolescents. The adolescent brain is particularly vulnerable. I also wear a hat on the Mental Health Review Tribunal where I review compulsory care in New South Wales. Eighty per cent of our work was due to cannabis—psychosis and all the catastrophes that happen. Eighty per cent had the same story: they started cannabis at 16 and by 20 suddenly developed a psychosis. There is another group who do take cannabis when they are 16—

Senator BOYCE—Medicate with cannabis, basically?

Dr Campbell—No, they are just trying it. The kids have paranoid episodes—terrible effects. They never try it again, but then they get schizophrenia. They are the sensitive ones. That is less than one per cent of the people I see. When 80 per cent tried it they felt great—it was comforting and calming; they took it because they could sleep. It is a very powerful drug. Its biological effect is to calm people down. Only people who are sensitive to schizophrenia have a bad reaction. However, it changes the adolescent brain and it does not mature. Then you have a pre-schizophrenic brain and then something happens or you have some amphetamine and, bang, you are in the system and you have the label of having schizophrenia. We are now just recognising that. I have known it for 10 years because I see it in the tribunal, but the departments did not know this and that overwhelmed our mental health services. We had four or five times the rate of psychosis to deal with. Once we had a very nice, gentle system and now we just have psychosis services. Fortunately, the rate is dropping. I think it is dropping because young people are waking up, but we do not have the message out there to clinicians and everyone else as to how dangerous cannabis is in adolescence. I do not see it affecting adults. Once you are 22, you can take cannabis and not get into trouble. It is a specific area that we need to be aware of.

CHAIR—Regarding the paper that you referred to that has just been released, could you send us the link?

Dr Campbell—It is in *Archives of General Psychiatry*. It is American. It was just last week, and I think it got into the papers as well.

Senator BOYCE—I think it was in the *Courier-Mail*.

CHAIR—Yes, but it would be handy to have the reference.

Dr Campbell—I will find it for you. The problem was that we did not have respective studies. We did not know whether it was chicken or egg, and now we do. Yes, cannabis is toxic to adolescent brains.

CHAIR—There was a show on SBS, I think, last year about the impact on adolescent brains. It was very interesting.

Dr Campbell—I think I helped make that.

CHAIR—It was very interesting.

Dr Campbell—That is the message we have to understand. You could decriminalise cannabis, but you would increase the problems. What you have to do is make sure the dealers do not give it to adolescents. That should be the real crime.

Senator BOYCE—That points to an awareness campaign, doesn't it?

Dr Campbell—A corollary to that is that we are now seeing people who stopped taking cannabis five years ago getting better and who have recovered.

Senator BOYCE—Adolescents?

Dr Campbell—They are now 30 or 35.

CHAIR—But they took it when they were an adolescent?

Dr Campbell—It takes about 10 years to get them sick and well again. It is a huge investment.

Senator BOYCE—Is that just some or all?

Dr Campbell—I have no idea because I am not in a position to get all this data. Because we do not ask about cannabis induced psychosis, we only ask about schizophrenia, we can never distinguish who has got what. But take it for granted that most cases of adolescent onset of schizophrenia in males are as a result of taking cannabis. That contributes to the high suicide rate, but it also has an enormous burden on communities, because these people never would have got sick if they had not used cannabis in the first place. It takes 10 or 15 years to get them better.

Senator BOYCE—You mentioned your Charmian Clift Cottages and the service that is available. You refer to the fact that suicide is a cause of maternal death and you note some British research. You do not know about equivalent Australian data? Does that mean that there is no equivalent Australian data?

Ms Rutledge—There may be. We were not able to find it in the time that we had to prepare our submission. But it is an area for further review and it is possibly an issue that could be raised with the New South Wales Department of Health. They may well have the data.

Senator BOYCE—But if you had difficulty finding it, it suggests that there is not a lot to be had? Is that correct?

Ms Rutledge—Yes.

Senator BOYCE—Can you explain to me why this is an issue we should be concerned about?

Ms Rutledge—The point we are making is that Charmian Clift Cottages is intervening at a very critical point in the life of women with a mental illness and their young children.

Senator BOYCE—How do they come to you?

Ms Rutledge—They come to us from the Department of Community Services or from hospitals from which they have been discharged. In some cases they come through direct referrals. We work very closely with the Department of Community Services because of the child protection issues involved. But it is a real partnership, finding an outcome that will meet the needs of a child and enable the mother’s recovery and reconnection with her child and the community. We see it as a vital service, but many of the women are at risk of suicide. Again, we do not know the numbers where it may be linked to postnatal depression or where it may be more serious and related to a psychosis. That is one of the services that we are about to evaluate. We do want to look for ways to grow, in partnership with government and others to grow that service.

Senator BOYCE—You say you are about to evaluate. I note you say here that it is a unique service. To your knowledge, unique in Australia or unique in New South Wales?

Ms Rutledge—To our knowledge, unique in Australia.

Senator BOYCE—A six-bed facility does not sound like a very large one for Australia?

Ms Rutledge—No. There is huge demand and we believe huge potential. The Department of Community Services is very interested in seeing it as a really positive intervention point.

Senator BOYCE—You do not have any sense about what percentage of your clients would have postnatal depression and what would be classed as ‘other’?

Ms Rutledge—No, but we will gather that data in the evaluation.

Senator BILYK—Are there any statistics Australia wide on postnatal depression and on the relevance or the numbers of suicides that are caused by—

Ms Rutledge—As I said, we were not able to find any in the time available, but—

Senator BILYK—You do not have any?

Senator BOYCE—We will try the department on that one.

Ms Rutledge—There might be something. It is something we will track down.

CHAIR—We will ask the department, because putting even more work on an NGO is not exactly appropriate.

Dr Campbell—Part of the problem here is the terminology. ‘Depression’ covers a multitude of sins, because postpartum psychosis will change. The young blokes are at risk with the drugs and alcohol, and it is the women who are at risk in having kids and a certain percentage do get in trouble.

Senator BILYK—What about young women with drugs and alcohol?

Dr Campbell—You just make it all the more complicated.

CHAIR—Certainly, this committee does a lot of work on many issues but, on alcohol, the evidence we have received is that there is increasing use of drugs and alcohol by young women.

Dr Campbell—Oddly enough, when women get pregnant they stop drinking. A lot of them stop drinking, so the alcohol ceases to be a problem. But out at Brewarrina they saw the lovely green stuff, the cannabis, and said, ‘It’s natural so that’s all right.’ So they shifted from alcohol to cannabis. We still do not know—I did a research study on what it was doing to the babies, but we never got that together. It is a perfect place to do it, because you know everyone, we have all the data there but no-one has ever sat down and put it together to show what the impact is.

Senator BOYCE—I have just been reminded about foetal alcohol syndrome.

CHAIR—I know this is a particular passion of Senator Adams.

Senator ADAMS—With respect to foetal alcohol spectrum disorder generally in New South Wales, as you are out in the bush, are you picking up—

Dr Campbell—I get young blokes coming in with that problem. They have a special set of needs. They often know that is the problem. A lot of information is out there.

Senator ADAMS—It is now becoming easier to diagnose than it was. They now realise that even people who they thought were autistic were not and that it stems back to this.

Dr Campbell—Recently, I saw one young guy who was well aware that it is a problem. His problem was getting a job. He had moved past that and moved on. But it is a big issue and will remain so. All my grandchildren are over in Sweden. Sweden has policies on alcohol, because it taxes according to the alcohol content. You can buy beer in the supermarket, but you can drink it all day and never get crook on it. You cannot afford to have wine and spirits, so there is a very different picture in Sweden. If we could introduce that, if nothing else, into rural communities we would make a huge impact on alcohol, health, jobs, injuries—the works.

CHAIR—You just touched an issue that I would like to strongly follow up, but we have run out of time. As I keep saying, and you probably have seen it here this morning, we keep running out of time with each of our witnesses. Each of them has so much to tell us and to contribute. We really appreciate your time, your submission and the work you are doing as well.

Dr Campbell—Thank you for your interest.

Senator BOYCE—We are very happy to take follow-up questions by email.

CHAIR—I think you have taken some homework already.

[11.47 am]

OAKLEY, Ms Karen, Executive Officer, New South Wales Consumer Advisory Group, Mental Health Inc.

DOYLE, Ms Rebecca, Senior Policy Officer, New South Wales Consumer Advisory Group, Mental Health Inc.

CHAIR—Welcome. I understand that both of you have been given information about parliamentary privilege and the protection of witnesses and evidence. We have your submission. I now invite you to make an opening statement and then we will ask you some questions.

Ms Oakley—First of all, I would like to thank the inquiry for this opportunity to represent to you the views of people in New South Wales who live with a mental illness. As you are probably aware, our role as the peak independent state wide body representing people who live with a mental illness is, at a policy level, working to achieve systemic change. The basis of our advice derives from information that we obtain through our core work, which involves a lot of regular interaction with consumers throughout the state. We have over 1,000 people on our network, accessible by email and internet. We undertake face-to-face consultations with consumers in each area health service throughout New South Wales and of course we derive from our knowledge base of 17 years in the field.

Our constituents are highly relevant to this inquiry as mental illness, as you are probably very well aware, is a significant risk factor for suicide. It is important to consider that the impact of suicide does not just occur when a person dies by suicide. Each suicide attempt has a significant psychological and often physical impact that can be lasting. Each attempt increases the risk of future attempts and increases the risk of death by suicide. Each attempt affects family and friends and can often lead to an increase in suicide attempts in close families and suicide death.

So to truly make an impact on people’s lives we need to work to prevent suicide attempts, not just deaths by suicide. We also need to ensure that the community and services are responsive to people in distress, meet their needs and, as a result, reduce the incidence of suicide, suicide attempts and the impact of any suicide attempts. To do this, there are a range of strategies that are needed, and many we outlined in our submission. But there are four key areas from our submission that we would like to draw particular attention to today: the need for stronger mental health literacy in the community; access to appropriate services; stronger, more accessible community services; and education and review of police involvement in mental health crises. I am going to ask Rebecca to speak to each of those.

Ms Doyle—It is quite an unfortunate reality that people who experience mental illness still face so many barriers caused by pervasive stigma and discrimination in today’s communities. Such stigma and discrimination can have several debilitating effects, such as preventing people from accessing services when they experience a mental health problem. It can also decrease social networks, which are imperative to keeping people well, and reduce employment options. Also, it can add to internalised stigma which is held by the individual. Even within the current mental health system, we hear a lot about stigma and discrimination being present in staff attitudes and behaviours—even staff that regularly interact with people who experience mental illness. I guess this is manifested through some staff holding negative attitudes towards people who experience mental illness and having a lack of hopefulness for their future.

The lack of mental health literacy in the community is a big contributing factor to stigma and discrimination. Mental health literacy is about people’s knowledge of mental illness, how to identify and manage it, and where to access support when it is needed. It also provides people with the resources and knowledge to respond to a situation where they or a friend are experiencing suicidal ideation or mental health symptoms. The taboo nature of suicide and mental illness, a lack of knowledge about it, and the overarching stigma surrounding suicide and mental illness continue to prevent people from talking about their problems and accessing appropriate support. The Australian government has incorporated into its Fourth National Mental Health Plan a commitment to improving community and service understanding and attitudes through a sustained and comprehensive national stigma reduction strategy. New South Wales CAG would like to stress the importance of the government actually following through with this commitment with comprehensive action. Such a campaign will need to include accurate information about mental illness, normalise people who experience mental illness, and encourage and enhance help seeking. It also needs to provide education on how people can go about accessing appropriate services and supports where needed.

The second key issue that New South Wales CAG wants to raise is access to appropriate services. Last year we conducted consultations in over 17 different locations across New South Wales and spoke to over 300 people who experience mental illness. A lot of people talked about the difficulty in accessing services before reaching a point of crisis. This was particularly prevalent in communities where there is a lack of appropriate services available and no after-hours crisis support or community support. It is also relevant for people who are unfamiliar with the mental health system and are faced with accessing it for the first time. Many people are forced to access the system through emergency departments, which are not adequately equipped to deal with mental health related presentations, and staff are not adequately trained in mental health and do not actually appear to prioritise it in an emergency situation compared to other presentations.

New South Wales CAG hears from many people about their experience of having to wait for hours in a stressful hospital environment before actually being able to see someone at times when they are actually suicidal. They are then often sent home without any follow-up care or support. People also talk about presenting to a hospital and finding it so stressful and such a long process that they actually end up leaving, even though they are still having thoughts of suicide.

This highlights several things that need to be addressed: the hospital triage system, which does not identify mental health as a priority; adequate staff training in responding to mental health presentations; and the need for more appropriate services to be available, such as psychiatric emergency care centres, otherwise known as PECC units, for people when they actually are at a point of crisis. There are also no adequate discharge planning processes once someone is actually being discharged to leave hospital. This is a significant issue and we know that the highest risk of suicide amongst people who experience mental illness is actually within the first 28 days after discharge from an inpatient or hospital setting following an acute episode of mental illness. Some consumers have even reported receiving no communication from mental health services after leaving hospital. New South Wales CAG feels that discharge planning needs to extend beyond the current minimum of making sure that the individual has somewhere to go or that someone has been informed of their discharge. There needs to be a process in place to ensure a continuity of care in the community as a component of any other strategies to reduce suicide in Australia.

I guess this brings us to our third key issue, which is the need for a much stronger community mental health service system. New South Wales CAG continues to hear from people with mental illness about the significant gaps in community mental health services across New South Wales. The last five years have seen a tightening focus in Australia on the inadequate balancing of our mental health system. There is an overemphasis on a hospital based acute care system and a systemic failure to develop and invest in a sound community mental health based system. These are key areas that need to be addressed if the state is to meet the needs of people with mental illness to ensure that people are actually supported to continue to live in the community, remain socially connected, experience minimal disruption to their life and maintain a recovery focus. There needs to be flexible, non-hospital based support in the form of step-up and step-down services in the community. A good example of this is the HASI program, the Housing and Accommodation Support Initiative, which has been seen to be quite successful, although there are not enough available places currently within that program.

There is also a significant need to boost case management services. We have heard of case workers having case loads of up to 40 to 60 people and this basically limits the ability of case workers to maintain regular contact, if any at all, with people. We have even heard of consumers being put forward to the Mental Health Review Tribunal for a community treatment order in order to be prioritised for case management services. New South Wales CAG feels that this is grossly inadequate, particularly for a first-class health system which aims to meet the needs of this community.

Consumers also call for increased and sustained funding to build a system of community participation and social inclusion options. It is widely recognised that social support is a key factor in prevention. Social support in the form of social activities is something that we continue to hear a need for in New South Wales. Also, such social support is essential in reducing suicide in Australia.

Another key area that we would like to highlight is the issue surrounding current police interventions with people who are experiencing a mental health crisis. Police are often the first called to respond to a person experiencing a crisis due to a lack of after-hours crisis services or because of a perceived danger to community mental health clinicians. Consumers have talked about their concerns about marked cars and uniformed police involved in a mental health crisis intervention and how this can be misconstrued as a criminal matter by other members of the community. This can result in feelings of humiliation and shame for the person who is actually in crisis, which can have a very real and long-term effect.

Greater care is needed to ensure that mental health interventions are not confused with criminal behaviour and do not further contribute to the stigma associated with mental illness. Crisis intervention teams need to include both mental health professionals and police located in each local area of command, and police interventions which include uniforms and marked cars need to be used only when absolutely necessary. New South Wales CAG also advocates strongly for appropriate and intensive training in mental health to be rolled out across the state for all police and new police recruits.

New South Wales CAG's recommendations to reduce suicide and suicide attempts in Australia are quite well detailed in our submission. As we seek our vision for all mental health consumers to experience fair access to quality services which reflect their needs, New South Wales CAG advocates the need for greater community supports and mental health literacy to ensure that the incidence of suicide and suicide attempts in Australia reduces.

Senator MOORE—I have one question on notice to do with privacy. There continues to be a very vexed debate about rights under and the operations of the privacy laws—the right of adults to say no to other people knowing their business and also the right in crisis of other people to know that. I am going to put that on notice because it is very vexed and I want some response about the current position of CAG on it. The second point could also be on notice. It is about the role of the consumers' network in the proliferation of networks that we are hopefully going to get up across the country and the state. Is CAG part of developing those networks? And do you have the capacity, which I think is absolutely essential, when there is a network created in a region to have the voice of consumers actively in it? It is a lot of responsibility on local people who want to be identified or not identified. How do you handle that to ensure that consumers' voices are heard? I know they are big questions. I do not know whether you want to have a go now or put them completely on notice.

Ms Oakley—I will talk about the second one just very briefly and I think we need to elaborate on that through a question on notice response. It is a big challenge. I guess we are only just starting to become aware of the networks that exist amongst consumers throughout the state and rurally, in particular. I am not completely sure about that reticence and the reasons for those networks not having been more formally integrated before. Certainly it is part of the work we are hoping to do progressively over the next few years to start building that into a systemic network too.

Senator MOORE—I have a follow-up question, Chair. I do apologise. The job of the LifeForce project is to identify and create these networks. Has CAG been intimately involved in the development of that and were you approached to give your view?

Ms Oakley—No, we have not been at all, and it is something we will follow up.

Senator MOORE—As will we.

Senator ADAMS—Have you got any representation on mental health advisory groups?

Ms Oakley—We have representation on a number at the Department of Health level, including the Clinical Advisory Council. At the local area levels, where they do have those advisory councils for the area health services, that is managed more at a local level than at the state CAG level.

Senator ADAMS—I was just looking at a lot of the government agencies that you have got problems with. Are you able to get your message through through an advisory position?

Ms Oakley—We are moving forward with that. Again, there has been a resistance to it previously in the past, coming from, I guess, a clinical model and often with clinicians saying, ‘Why do we need consumers on here? We know what’s best.’ So we are still facing those barriers but slowly overcoming them over time.

Senator ADAMS—With the emergency department and especially the triage area, that came up very strongly in Queensland yesterday. Do any of your accident and emergency departments have any mental health emergency areas with a psychiatrist or a psychologist?

Ms Oakley—They do have some. Some units have now got what they call a PECC unit—psychiatric emergency care. They are the specific units that would manage those more.

Senator ADAMS—So as soon as a person presenting to accident and emergency got to triage they would be taken aside to a different triage area, or what?

Ms Oakley—My understanding is that, yes, in some areas that is how it is working. The PECC units have not been rolled out in all hospitals throughout the state. There are obviously funding and resource issues implicated with setting up a PECC unit as well. But they have been found to be a good model of care for consumers.

Senator ADAMS—So you would support those?

Ms Oakley—Absolutely.

Senator ADAMS—That is good. I just noticed the other one: discharge planning seems to be a huge problem wherever one goes, but that is something that you are really pushing very hard?

Ms Oakley—Absolutely, and we are aware that New South Wales Health is reviewing that and, hopefully, expanding its discharge planning policy to actually be a lot more of a comprehensive transitioning of care policy. We will be integrally involved in that.

Senator ADAMS—Are New South Wales step-down facilities pushing along with that particular model?

Ms Oakley—When you refer to the New South Wales Health step-down facilities, what are you referring to?

Senator ADAMS—When somebody is being discharged and coming out of a hospital setting then going to the step-down facility, which is the conduit between them going right out into the community just as a support area rather than being in the hospital side. It is just a way of actually working that person through to going back to the community and where they have come from.

Ms Oakley—From what we are hearing from consumers there are not very many of those facilities throughout the state, and that is a big downfall. Whether it needs to be a residential facility or a different model of community support in that step-down phase is a question I think we really need to consider, but certainly I think it is an inadequacy at the moment.

Senator ADAMS—Often the reason that the person has been acutely ill in the first place is where they are living, so in that area it means that they can come back to that central place so that they are not having to go back to their own area, but there is time for them to work through to find a more suitable place to go. That plays a very big role in getting the person rehabilitated properly.

Ms Oakley—Certainly for some people, yes. I guess another component that we do face, particularly in New South Wales, is that there are a lot of people who are transported to a different part of the state for their treatment and care. They are finding that really difficult because it is dislocating them from their community, and the transitioning back is incredibly difficult because community life has gone on without them while they are going ahead.

Senator BILYK—Thank you for your submission. I noticed in reading through it that you did touch on the effect of the media—negative campaigns there and the need, maybe, to have an anti-stigma campaign. Could you elaborate on that a little bit for the committee?

Ms Doyle—What we have heard a lot from consumers is the need to address stigma and discrimination. There has been a program in New Zealand—Like Minds, Like Mine, or something like that—which has actually shown to have a good result in terms of reducing negative attitudes towards people with mental illness. I think you can see it as well with programs such as what beyondblue has done in promoting depression and awareness around that within the community. We have started to see a change in community attitudes towards people who experience depression, however it has not extended to other types of mental illness such as schizophrenia and bipolar. I think that within the community there is a real lack of mental health literacy around even how to identify when a person is showing symptoms of possibly experiencing a mental health problem and also how to act on that and even where to go. I guess that is why a lot of people are presenting in crisis to emergency care settings, rather than actually seeking help within the community. Does that answer that question?

Senator BILYK—It does, thank you.

Senator BOYCE—In Queensland yesterday, we had some strong evidence that people who were in hospital having self-harmed were being stitched up without anaesthetic. Have you had any anecdotes around this? Are you aware of this happening in New South Wales?

Ms Oakley—We have not heard of it from consumers at all.

Senator BOYCE—I was glad to see that look of shock on your face.

Ms Oakley—I guess one of our concerns, though, is that when people do present with self-harm there can be a negative attitude of mental health clinicians towards that about: ‘Oh, this person’s seeking attention. They’ve done it to themselves; too bad.’ And often, because self-harm can be associated with personality disorders and they are a very, very stigmatised group of mental illnesses, that can actually exacerbate the attitudes that people are facing. Fortunately, we are not hearing about the nonuse of anaesthetic, but I guess the pain of the bad attitudes is coming through.

Senator BOYCE—And the sense that you are not a deserving recipient of resources and time.

Ms Oakley—Absolutely.

Ms Doyle—And we certainly hear a lot about staff comments to the people as well, expressing that negativity directly to the consumer.

CHAIR—That came out yesterday, too: ‘You’ve been stupid.’

Ms Doyle—Yes.

Ms Oakley—Absolutely.

Senator FURNER—I ask you to take my question on notice because it is quite vexed. It is around what you have quite correctly identified as being an issue—which seems to be consistent with what is coming out—with the discharge planning. Could you give me an idea of what the model would be of the sort of planning you would like to see? Also, you have come up with a description of the person being a discharge community officer. Can you identify what the duties of that person would be and also what sort of accreditation you would expect of that person?

Ms Oakley—Absolutely.

Senator FURNER—Thanks.

CHAIR—I have one or two questions that I would like to quickly address. You have given some quite comprehensive information in your submission about interaction with the Police Force. Other people have mentioned it, but you have gone into the issues in quite a lot of detail, particularly as they are, as you say, the front-line people who are often dealing with mental illness. What is the level of resources that are currently going into support for training for police services?

Ms Oakley—Off the top of my head I cannot remember the numbers. It would be a good question to ask the Department of Health. They are working with a particular unit with the Police Force and they have developed—from the understanding I have of that program and the presentations of it that I have seen—a very comprehensive program for training officers. The difficulty with that program is that, because it is a four-day intensive program, it is only being aimed at certain levels of workforce. I think the aim is 10 per cent of front-line staff being trained by 2015.

CHAIR—Did you say 10 per cent?

Ms Oakley—Ten per cent by 2015, which, from our perspective, whilst we appreciate the resource implications, is really not an adequate situation.

CHAIR—I am not an expert on law enforcement training, but I would have thought that this issue would be a key part of their competency.

Ms Oakley—We would have hoped.

CHAIR—But it is not. Obviously there are the police who are currently in service and then there are the police who are currently being trained. But, as far as you are aware, is it now part of their basic training?

Ms Oakley—My understanding is that there is a component within their basic training but that it is not comprehensive enough to deal with the situations that they are facing when on the job. Considering it as a resource issue, one of the things that we would probably very much argue is that a lot of the skills and knowledge that people need to deal with people in a mental health crisis can be applied in a lot of situations—de-escalation, communication skills, being human; those sorts of things—and I think if it is approached in a different way it can be achieved.

CHAIR—Thank you. I have another completely separate question.

Senator MOORE—I have a follow-up question. Has CAG been involved with the police department in developing this training?

Ms Oakley—Not to date, no. We do understand, however, that they have been working with the Schizophrenia Fellowship and have consumers and carers involved in that.

CHAIR—This is a completely separate question. It is to do with how you network nationally. Is there a specific forum where consumer groups talk about mental health issues?

Ms Oakley—That is a more complicated question than you probably realise. There is the National Mental Health Consumer and Carer Forum, which has one consumer and one carer representative from each state. The purview of that committee is fairly restricted, and the capacity of doing consultations and ensuring that it is a really representative view from each of the states is challenging because it falls on the shoulders of an individual that is not necessarily linked in with an organisation. Fortunately, our representative is, but it is not the case throughout. There was at one stage an Australian Mental Health Consumer Network. You are probably aware that that had to cease—I see your faces—and that there is work being undertaken to look at a new network. But I think one of the weaknesses is that there is not at the moment a place where the peak organisations come together and work comprehensively together.

CHAIR—Thank you very much for your submission, your time now and the promise you have taken on to do extra homework.

Ms Oakley—Thank you.

[12.17 pm]

GADDIN, Mrs Dianne, Private capacity

ROD, Mrs Janine, Private capacity

CHAIR—Welcome and thank you for coming.

Mrs Gaddin—I speak for the thousands who would like to be given the opportunity that I have been given today.

CHAIR—Would you like anyone to join you at the table?

Mrs Gaddin—My daughter could come and sit next to me.

CHAIR—You are more than welcome to. As you know, we have a number of hearings planned around Australia and we will be hearing more people's stories as well. I just wanted to let you know that. I understand that you have been given information on parliamentary privilege and the protection of witnesses and evidence.

Mrs Gaddin—Yes.

CHAIR—If you would like to make an opening statement and then we will ask you some questions.

Mrs Gaddin—I am truly honoured to be sitting here today and to be able to speak to people that I know are hearing me. I stood in this room on 7 August 2002 at the mental health inquiry, and I was the only person speaking that day that had not lost a family member to suicide. Sadly, my status has changed. I am now part of that family. What I would like to say is that I naively believed all would be well and that the government would act on 120 recommendations which resulted from the inquiry. What I have learned is that politicians just do not hear what families and carers have to say. They think they know all. But how can they, since many of them have not been touched by suicide or mental illness? We are on the other side of the desk. We and our families live daily with the stress and anxiety. We are the ones who will forever live with the after-effects of suicide. We are the unsung heroes at the coalface. I am a survivor. I attempted suicide. It just got too much for me. I no longer had the strength, the energy, the resilience, to fight for basic human rights when it came to my late daughter, Tracy. It seems to me that apartheid had followed me from South Africa, because apartheid is alive and well when it comes to mental illness. Your rights have been stripped. You have been disempowered by your mental illness.

This is further compounded by the fact that there is no automatic right to be admitted to hospital, despite being psychotic and very unwell. Your basic right to stay until such time as you are well enough to cope in the outside world has also been taken away from you. You are now trapped and enveloped by the revolving door. You are at the mercy of the registrars as to whether you can or will be admitted to hospital, no matter how desperate the need for admission is. I must add that, even if the registrar deems the person to be so unwell as to need hospital admission, his hands are very often tied because there are no beds available.

If this is the case, then what other support systems are in place? You cannot just throw the person out onto the street, as was often the case with my late daughter, Tracy. Our population is increasing daily, and yet despite this what is needed to service this growth is diminishing. On several occasions, despite Tracy being so severely unwell, she was denied hospital admission. On one occasion she was so psychotic and behaving in a most bizarre manner. I was terrified as to how my husband and I were going to cope, because they would not admit her. My strength and coping skills were sapped and I saw no other way out but to try and end it. I took a massive overdose. Fate was on my side, because I am here today. Someone up there said there was still too much for me to do, and that is what I am doing. That is why I am here today. That is the legacy that Tracy left me to do.

I was to stand before the Lifekeeper Memory Quilt, but unfortunately the Salvation Army have been unable to deliver this magnificent quilt for you all to see, because it speaks volumes. It is a quilt of 62 survivors on 60 squares. One mother had lost three children to suicide. I am very proud to be part of the Lifekeeper Memory Quilt family.

Tracy could no longer cope with the loneliness and isolation, and she took her life at the Gap. Schizophrenia was not the reason. A short time before her final, fatal step her drivers licence had been cancelled. Her parking infringement could not be waived, despite letters from her case manager and her treating psychiatrist explaining why she had parked where she did. When she finally went to pay, she did not have enough money on her, and so the fine of $648 was the reason to cancel her licence. The last vestige of independence was taken away from her. A few weeks before she took her life, she had been refused for rehab training as she was deemed not to be well enough—no words of comfort and hope, just a refusal.

She also received a letter from the department of housing threatening her with eviction because she was never available to have maintenance work done in her unit. She was hardly available because she was in hospital most of the time. She was sick. She was being punished for having a mental illness. What kind of system is this? Do those bureaucrats understand mental illness? Do they have any idea?

On 14 November 2005, unbeknown to my husband and I, Tracy took my car and drove to the Gap, where she had been on a number of occasions before, and she took the final step, we believe, the following morning. I believe there is so much we can do as a society, and government, to minimise these tragic events. We need to take ownership. Suicide is everyone’s business—yours and mine. There needs to be assistance given to families and consumers after hospital admissions—assistance given to them to navigate the mental health system, which is a nightmare. We need to train more psychiatric nurses and doctors. We need to open up more beds and never, ever turn away those in need of admission. Who has the right to judge who is mentally stable enough so as not to require hospital admission?

I have been endlessly campaigning to restore Rozelle Psychiatric Hospital—this is where Tracy had her first serious admission. No, it is not a state-of-the-art hospital. It has been allowed to rot and decay. Concord Hospital is the new hospital with the finest facilities. Rozelle is the one hospital where Tracy healed the quickest and the one hospital she never ran away from.

There were no gates and no fences. I have heard a number of people tell me exactly the same. There was something about Rozelle Hospital that helped people get better. The government was ready to give away Callan Park and Rozelle to the University of Sydney but, because of extreme pressure brought to bear, this decision was thankfully overturned. I might mention that the number of beds at Concord Hospital does not replace Rozelle beds. There is still a big shortfall.

Please stop closing mental health centres. Since 2004 I have campaigned tirelessly to save both Chatswood and Cremorne mental health centres. These centres actually save governments money because very often hospital admissions are prevented. A friendly, caring objective teamworker is there to listen and do what is needed and, more often than not, it is just the care and kind words and perhaps an injection that prevented Tracy from being hospitalised. Don’t close them. Don’t move them onto hospital grounds; leave them where they are. I am not sure how my husband and I would ever have coped without the Cremorne team. They were there for us when we needed them.

Jobs need to be created to help those that are only able to manage a few hours a day. Work, albeit just a few hours a day, helps to restore self-esteem. It helps to give a little financial security, and most important of all it will lessen admissions to hospital. A recent case is Cornucopia and MARS, which has been given a lot of publicity to highlight the anguish families and consumers are going through because of government bungling. It should be the government departments that should be closed down for their lack of understanding and inefficiency, not the disabled workers. Cornucopia and MARS must remain open, and I beg that it be allowed to continue and give the security and hope to all those that work there.

When suicide hot spots are known, steps to prevent suicide must be taken no matter what. A year after Tracy died I decided that something must be done at this uniquely special area in Sydney, the Gap. I have worked closely with the Woollahra council to implement a master plan for the Gap Park upgrade. The Woollahra council have passionately supported me together with the Black Dog Institute but I have been given the run-around by every minister I have written to. Nobody answers my questions but they rather give me the blah. Is the reason for funding being turned down because it may be in a Liberal seat? I asked the Prime Minister this question in one of my eight letters that I wrote to him. Of course I did not expect an answer but I wanted to show that the public is smart.

Suicides are happening at the Gap almost on a daily basis. The government knows this and it just buck passes and chooses to ignore what needs to be done for a pittance when one considers that we gave $3.8 billion in foreign aid last year. Some of the responses I got from different government ministers just shocked me—for example, there is no evidence to show that hampering access lessens or prevents suicide. One minister even wrote to me to say that this plan does not fall under suicide prevention. Need I say more?

If we can be so generous with our foreign aid, we need to first look after what needs to be done at home. There should be no homeless people on our streets. We need more beds in psychiatric hospitals, more trained and better paid psychiatric nurses, and I could go on and on. Charity begins at home.

I have been anxiously waiting to hear whether the $1.4 million needed from the federal government to complete the upgrade of the Gap will be given. The answer has been continually delayed. Who will take ownership for the continuous suicides that take place? Who will comfort the families, like me, who have lost a loved one there, when steps could and should have been taken to prevent this? I shall not give up until the master plan has been implemented. I want to tell the rest of the world that the Australian government is serious about preventing suicide.

The same hoo-ha has been taking place at Northbridge, where the RTA are going to erect fences at this known hot spot. But we have North Sydney and Willoughby mayors contesting this. We need to know the real truth about suicide statistics. There needs to be a policy of open disclosure when suicide happens in care. My daughter’s death certificate showed the reason for her death as ‘multiple blunt trauma’. Is this a ploy to underplay suicide? When we know the real truth and the breakdowns in the hows and wheres, we can fix the problem. I would like to end with a quote from a speech by Robert Kennedy that has inspired me.

> Each time a man stands up for an ideal, or acts to improve the lot of others, or strikes out against injustice, he sends forth a tiny ripple of hope, and crossing each other from a million different centers of energy and daring those ripples build a current which can sweep down the mightiest walls of oppression and resistance.

That is why we are here today. Thank you.

CHAIR—Thank you. We have got a few minutes. Do you feel that you would like to take some questions?

Mrs Gaddin—I am fine.

Senator BILYK—Thank you, Mrs Gaddin, for your submission and for appearing before us today. Obviously it is not easy to do, having been involved as you are with your daughter’s suicide. I am interested to know what support might have been offered to the family. Bearing in mind that you know of other people who have been through this, do you know of any support systems that are in place for families or for those who might have attempted suicide? You are telling me that there is nothing at all available?

Mrs Gaddin—I have not been given any support. I actually wrote to Tony Abbott, who was the health minister at the time, saying how indignant I was to receive this massive envelope with support brochures and things just after my daughter died. I was certainly in no state to understand even half of it. I think that they needed to approach me in a different manner.

Senator BILYK—Did your GP not have anything to suggest to you?

Mrs Gaddin—Whatever help I got I sought myself. I went for counselling. I found a support person to help me, but it was not offered. I had no idea where to turn and neither did my husband.

Senator BILYK—Thank you.

Senator BOYCE—Mrs Gaddin, do you know how much it would cost to undertake the changes that you are suggesting at the Gap?

Mrs Gaddin—We are short of $1.4 million, which I honestly believe is a pittance in the scheme of things. I do not believe one can put a price on saving a life anyway. There is so much money wasted, and it has to be done. I cannot understand why they are digging in their heels and ignoring the problem. I attended the second postvention in Melbourne, and in it was a letter from the Prime Minister commending the Salvation Army for the wonderful work they are doing with suicide and acknowledging that suicide is a problem in Australia. But two days before that I received a letter saying that the funding had been turned down and that we must apply in the next round of funding. Instead funding was given to upgrade sports ovals and a flea circus. Surely life comes before pleasure.

Senator BOYCE—When you commented before about being in the roundabout I checked the New South Wales Suicide Prevention Strategy, which is in the evidence they have given us—and we will be talking to them this afternoon—and the fourth subpoint of their first action talks about reduced access to the means of suicide and that that is the job of New South Wales, including the area health services. That is certainly something we can follow up with them, but I can understand that it is inexplicable that nothing has been done about it from your perspective. You mentioned Cornucopia and Mars earlier—can you explain what they are?

Mrs Gaddin—I am sorry; my daughter did tell me that I must not make assumptions that you would know about it.

Senator BOYCE—I am from Queensland; that is my excuse.

Mrs Gaddin—It has been highly publicised. There are two coffee shops and I think a little gardening place. It is attached to the hospital and people who have schizophrenia and various other mental illnesses work there—albeit for a pittance but they do work there. When the threatened closure came about people wrote to me because they know I am always putting things in the paper et cetera and they asked: what do we do, who do we turn to? People have worked there for eight to 10 years and have hardly had hospital admissions. It must say something—that these people’s self-esteem has improved, that they have a reason to get up in the morning and that they have somewhere to go. It is a family, and the stress that is taken off families and carers is enormous. These people have all collapsed now at the thought of this being closed, but it is only government departments that could not agree about how to manage these two cafes. That is not a reason to close them down, but apparently they have been given a reprieve.

Senator BOYCE—It sounds as though your actions are achieving something. Thank you, Mrs Gaddin.

Senator FURNER—Firstly, I thank you for appearing before the committee today. I assure you that all the members on this committee have an interest in this subject and in greater health initiatives. You were in the audience when the previous witness was giving evidence about posthospital admissions, and I am wondering, given that you have lived through the experience, what sort of ideal model you would determine as being appropriate.

Mrs Gaddin—It depends on the nature of wellness when the person is released from hospital. More often than not Tracy was discharged when I knew she was clearly unwell. A CTO was slapped on her but she was not in a state such that she could understand the meaning of the CTO. She would not turn up for appointments, she did not have a diary and she had no idea whether it was Monday or Friday. It is all very well having something like that in place but they need to ensure that there is someone else who could perhaps oversee that she turn up to an appointment. I think that is very important. I also do not believe, especially after a long admission—because Tracy was sometimes in hospital for as long as six to seven months—that you can come out and just pick up from where you were before you were hospitalised. As has previously been said, there needs to be a step-down program and assistance. That is my feeling.

Senator FURNER—So a staging process?

Mrs Gaddin—Absolutely.

Senator FURNER—Some sort of halfway house or whatever.

Mrs Gaddin—The family does not cope. I knew nothing about mental illness before my daughter became ill, and it is a terrifying experience. I had no idea as to whether I should be hard, whether I should be difficult or whether I should give in to her every whim. You have no idea how to deal with it. You live with guilt—did I, why, should I? I could have—maybe. It is a difficult situation and there needs to be help for families and carers to deal with patients being discharged from hospital.

Senator ADAMS—I am going through all these things and wondering how we can make things better. I really appreciate your attendance today. The support package arrived at the wrong time for you, but have you looked at that since to see what services are available? Or did you just throw it away?

Mrs Gaddin—I was in a state, as you can well imagine—

Senator ADAMS—I can, yes.

Mrs Gaddin—and I cannot even remember what I did with it. But I do remember opening up this big envelope with lots and lots of things in it.

Senator ADAMS—Do you know where it came from?

Mrs Gaddin—It came from the Department of Health and Ageing. That is why I wrote to Tony Abbott immediately. I was most indignant. He wrote me a very nice letter. Two paragraphs written in his own handwriting were illegible, but I was very touched that he was affected by what I had to say and that he would perhaps review what needs to be done. My daughter died five years ago. Things may have changed, but there was nothing out there. I had to access my own psychiatrist and my own support group. Something my daughter and I feel very strongly about is suicide support for families and carers after there has been a suicide.

Senator ADAMS—It is terribly important. If you look at some of the submissions, some very good information has come from bereavement groups set up specifically for that, but unfortunately there is not enough support. They are self-help groups that have come about when people like you have gotten together and decided that something has to happen. You obviously felt abandoned. You did not know where to go.

Mrs Gaddin—I will say one thing. My friend Tony Humphrey from Speranza was there for me. He did help me a lot because this is what he does. I am sorry that I neglected to mention Tony, but he is not government funded or anything.

Senator ADAMS—A number of these groups are not, unfortunately. It is something that as a committee we will be working on and making recommendations about.

Mrs Gaddin—It is very important.

Senator ADAMS—Your evidence will help. Despite the fact that one may think nothing is happening, I hope that the committee can come up a recommendation that will help in that respect.

Mrs Gaddin—It is absolutely essential because I believe that it can perpetuate suicide. I attempted; I survived. I then lost my daughter. It can precipitate those feelings in me again. I am lucky it did not because I got so involved in my advocacy. I threw myself into it because it was the best way for me to cope and move forward and know that my daughter did not die for nothing. But very few people have that.

Senator Boyce interjecting—

Mrs Gaddin—Yes.

Senator ADAMS—That is right. You have done very well.

Mrs Rod—I am Dianne’s daughter. I am a psychologist and I work with people who are bereaved by suicide. When my sister suicided I was not working in that field, but I am a health worker and was not a sure what was available for me. In looking at support groups, I did not want to go out to a support group in Chatswood if I lived in the eastern suburbs. Distance was an issue. There was just nothing available. No-one approached us; no-one gave us any guidance. You are so overwhelmed and so bereft and you are just left floundering. To get a big envelope with mounds of information is too overwhelming. Perhaps someone could have come to visit, which is what I do now. If I hear of someone bereaved by suicide I visit. I just put out a hand, listen, give some suggestions and then step back. When the person is ready they will approach you.

CHAIR—Thank you very much.

Mrs Gaddin—I wear green for suicide and purple for mental health.

CHAIR—Thank you for coming and sharing your story. It is much appreciated; we do value it. All of us take this very seriously and want a sea change.

Senator BOYCE—Coincidentally, they are the colours for strong women as well.

Proceedings suspended from 12.44 pm to 2.14 pm

[2.14 pm]

METCALF, Mr Atari Tania, Member, National LGBT Health Alliance

ROSENSTREICH, Ms Gabi, Executive Director, National LGBT Health Alliance

CHAIR—Welcome. I understand that you have been given information on parliamentary privilege and the protection of witnesses and evidence. We have your submission. I would like to invite either or both of you to make an opening statement and then we will ask you lots of questions.

Ms Rosenstreich—I am here representing the National LGBT Health Alliance. We are a very new national peak body of organisations working to improve the health and wellbeing of people—lesbian, gay, bisexual, transgender, intersex, queer, sistergirl et cetera. So we work generally around sexuality, sex and gender diversity and the various health implications associated with sexual orientation and gender identity.

The alliance is very new. We were formally established last year. I have some basic information material that may be of interest to the committee. The alliance is a peak body, so we are not a service delivery organisation. We can give you some information, because our members are generally service delivery organisations, but there may be points where I cannot provide the detail in my answers that you would be interested in; however, we can get that information easily.

Currently, I am the only staff member. We are entirely funded through community-raised money, and that is relevant to some of what I will be talking about. Essentially, the alliance is a framework for bringing together the voices of those working in the area. The Inspire Foundation is one of our member organisations, so Atari is accompanying me today as a representative of one of the member organisations. He has a lot of expertise in this area that I am sure we will touch on.

The subject of your inquiry, suicide in Australia, is incredibly important for LGBT communities—that is the acronym we work with. There are a lot of gaps in our knowledge, but there are some things we really do know. One of them is that we are dying: a significant number of people in our communities are attempting to take there own lives and often succeeding. The statistics are in our submission. We can go into more detail on that if you are interested, but they are very shocking and completely invisible in most of the research and work done in this area.

We know that there are specific issues for specific groups within the broad LGBT framework. That interrelates with other social groups that, as I am sure the committee is already aware, have particularly high risks, such as Indigenous Australians, young people, people in rural and remote communities et cetera so that does not stop when somebody comes out as gay, lesbian or transgender.

We also know is that these incredibly high rates are strongly related to social factors. We know a lot about some of the causal factors that contribute to the high rates. They primarily have to do with discrimination, social exclusion, isolation and issues that relate to those, such as high drug and alcohol use, experience of violence, disengagement from forms of civic participation et cetera.

One thing we do not know is exact numbers, and that is because there is very little data collection. We do have some really good research that gives us good indications, but they are always going to be underestimates. That is partly because one thing we also know is that a lot of people who attempt suicide reveal later that coming to terms with their sexuality or gender identity was a core contributing factor but they had not talked to anybody about it beforehand, which means that for a lot of people who do die this may well have been a contributing factor and we will never know. So, for that reason alone, it is an underestimate.

Senator BOYCE—And they may not have identified as—

Ms Rosenstreich—Exactly. In very many cases they have not. We know that young people, at around age 16, often make their first attempt at suicide and most of those young people have not revealed to anybody what they are going through. We also know very little about how issues such as the development of resilience interplays with some of the risk factors and how we can work more effectively there. We know a bit, but there is an awful lot more that we need to understand. We also know that current initiatives are not working for these populations and that the rates remain really high. We know that that has something to do with the lack of acknowledgement of social determinants and the pure invisibility of these communities. We know that it has something to do with the lack of targeted services and resources and that LGBT people tend not to use mainstream services. They fear discrimination and sometimes they experience discrimination if they use them. Often if they do use them they hide the fact that they are dealing with issues of sexuality or gender identity, which means they are not getting effective care. There is a complex of factors there.

We also know that this is partly to do with the fact that mainstream services do not have this community on their radar. It is not anchored in policy frameworks or in guidelines anywhere. There is such a norm of social exclusion and not talking about these issues that that is reproduced in services even if they think they are working for everybody. So it is a catch-22 situation—it is part of what causes the problems and it is part of what continues to maintain them.

We see key priorities for action in increasing visibility to explicitly anchor these communities and their issues in policy frameworks. We know if it is not explicit it does not happen and there is currently no mention whatsoever of these communities in the National Suicide Prevention Strategy, the mental health strategy or related policy frameworks. We know that having accessible, inclusive generic services is helpful. Not everybody will go to targeted services—they will often go to an A&E department or their GP. They need to be helped when they do so. We also know, though, that targeted services tend to be effective and there will continue to be a need for them. We also need visibility within research and reporting, including coronial data collection and research generally. Another key area for action is including a social model of health in the discourse. It is currently very dominated by a medical model. It is not that we discount that, but it is not well balanced by a consideration of the social factors that play a role.

The other key factor we would like to emphasise is that partnership is essential to be effective. Currently the voices of these community members are not being included in the development and delivery of policy or in the evaluation of programs and services. The alliance was partly formed to be a mechanism to assist with some of those voices, with the expertise of our membership assisting government to work effectively for these communities. We are currently entirely community funded. There has been very little partnership from the other side and that partnership is required generally, an open-doors approach. The sector needs to work more across silos. Basically, it is very much a silo discourse at the moment.

Ultimately, we think that all work done under the National Suicide Prevention Strategy and generally in this area in Australia needs to be explicitly inclusive and ultimately needs a whole-of-society approach, but targeted work around mental health and suicide definitely needs to be prioritised. There has been silence and invisibility for too long. Thank you.

Senator MOORE—Mr Metcalf, do you want to add to anything without using any kind of technology?

Mr Metcalf—As Gabi said in her opening statement, there is a lot we do not know but what we do know and what we have known for over 15 years in Australia is that people in the Australian community who are lesbian, gay, bisexual or transgender—and that amounts to somewhere at least 11 per cent of the whole population—are up to 14 times more likely to take their own life than the general Australian population. There is significant variation in that statistic, in part because of the difficulties regarding the research. But we do know that that is completely unacceptable. In the mid-nineties we saw some headway. Under the ‘Here for life’ National Youth Suicide Prevention Strategy, there were some initiatives, some targeted work, and the evaluation of those was quite promising, particularly in the context of peer support models. But it mysteriously disappeared off the agenda around 2000. In 1999 that funding ceased and since then it has not re-emerged. It is quite difficult and I would draw short of speculating about where those trends have gone, because we simply cannot; there has not been any new research into the area in terms of attempt rates and mortality. Sufficed to say, from the consultation conducted through the alliance, in putting these submissions together from the service providers on the ground, it is still incredibly tough to grow up with a sexuality or gender identity that is not conformist with social norms in Australia.

Senator MOORE—You have said that the alliance is self-funding and does not have any support from government or major sponsors in that way. I do not always carry around large books like this and just read them but this book lists funded programs under the current funding. I have been through it a couple of times and I do not find reference to any particular issues around GBLT—sorry to use the acronym but I always forget one group if I do not use it. I do not find any reference in it though I do find generalisms which people could use, if they had the will to do so, to actually include people’s experiences and service delivery. I am interested in your perspective on whether it is an oversight or a direct exclusion. I know it is a big question, but I am interested in your opinion of that exclusion, first of all, from the general plan, where you are not mentioned at all, and from all these funding programs, some of which are focussed quite specifically on youth. I am wondering what you believe.

Ms Rosenstreich—I think it is a combination of factors, one of which is the exclusion that partly results in the poor health outcomes that we have generally in these communities. In particular, mental health and suicide issues do not stop at service delivery, organisation or policy areas. Some of it is value laden in discrimination. Some of it, though, is simply not on the radar. It is invisible. It is hidden in general things like, ‘We work for everybody,’ ‘This is for all Australians’ and ‘We can’t name this group, because it would be somehow making it special’. It is politically risky still, in this day and age, to be drawing particular attention to that.

Senator MOORE—But you can name other groups.

Ms Rosenstreich—Exactly. So some groups are able to be named. This particular group is seen to be somehow risky and then special if we name them. But we know from evidence that, unless it is named, it is not addressed.

Senator MOORE—Yes. It can be lost.

Ms Rosenstreich—It is a total catch-22. I think that is actually most of it. There is a sense that, if you add a chapter or make a specific funding pool, you are somehow privileging a group—which frankly is bizarre because this is a group that has been excluded so specifically for so long that it would actually be quite appropriate to invest specifically in this group to help it slowly get to the same point as other population groups. There is a lot of caution there and a lot of lack of knowledge about how that might work. That is partly why the alliance has been set up—to assist that. It is often not that complicated.

Senator MOORE—One point is that even under Inspire, which I know has the group particularly there as part of its whole basis, when you read the information that we get about the Reach Out program, there is no mention in the dot points that we get about GBLT. I just find that worrying in that I know that Inspire consider it to be a priority. The other point is about—you put so much in your submission—but older people are often overlooked. I think we are becoming more aware about young people and the way people communicate. But I was particularly impressed by your comments in the submission about the special needs of people who have, for whatever reason, been quiet about their position and now, for many reasons, often for good, are now being asked to identify more publicly—and the mental health issues surrounding that. I thank you for drawing that to our attention. It is something the committee will have to consider.

Ms Rosenstreich—Thank you for noting that. One person said to me very recently that, in an interview she had been conducting, a respondent had said that she was seriously preparing to commit suicide, before having to enter aged-age facilities. It was just part of her plan. And she wanted to make sure she did not miss the right point in time when she could do that independently.

Senator BOYCE—Sorry, could you just expand upon how important her sexuality was to that decision, because, I mean, my mother might say the same thing.

Ms Rosenstreich—From my understanding, in that particular case it was a—actually, no, I cannot comment on that case, because I was not part of the research. But, generally, a lot of the time it is about an experience in the past of discrimination. Especially among older men, who have lived through criminalisation of sexuality and have sometimes been imprisoned or feared imprisonment, there is a real distrust of institutions. There is a really deeply ingrained fear of being dependent on agencies. There is an assumption that they will be treated badly by service providers—and that is not an unfounded assumption on the basis of the research that we have, not necessarily badly intentioned, but certainly ignorant. To that extent it has a lot to do with sexual identity and experiences with government bodies. If we think about the circumstances of transgender people, there is a real fear of being vulnerable to care and, for some people, especially older people, and a fear about what sort of treatment they are going to get, how they will be responded to. Nobody wants to be in a situation where they are treated as a freak, let alone when you are old and vulnerable.

CHAIR—Particularly with the cohort that will be going through in the near future, when they have been discriminated against all their life.

Senator BOYCE—If everyone in the dining room thinks you are a freak.

Ms Rosenstreich—Exactly.

Mr Metcalf—Can I add on that point as well that it is fairly recent history in Australia that it was decriminalised to be homosexual. Older people in particular have lived through that and in some cases it remains perfectly lawful to discriminate on the grounds of transgender status. In Western Australia it is perfectly legal to refuse goods and services unless that person has been issued with what is called a ‘gender assignment certificate’, which is very difficult to obtain. Many transgender people cannot obtain one. So, for those people, they may well be refused or dismissed from a facility, and that obviously affects people of all ages. There is still quite widespread discrimination within the community, and different parts of the community are absolutely experiencing it differently. It is one thing to live in Darlinghurst and be surrounded by a fairly supportive, inner-city, progressive social situation; but rural Australia, remote Australia and outer suburbs are not pleasant places—are in fact very hostile—for many people in Australia.

Senator MOORE—Wesley Mission has a particular program for which they are funded to establish networks for people across the country, and it is hoping to spread that widely. Has your group been involved or consulted by Wesley at any time about the issues you would have or about your willingness to be involved in any of the networks that are being set up?

Ms Rosenstreich—The alliance has definitely not been approached in any manner. I cannot say that none of our members have; I have not checked.

Senator MOORE—Could I put that on notice, Gabi?

Ms Rosenstreich—I am very happy to check.

Senator MOORE—I do apologise. I should not be so informal. Can you just check whether the people who have identified themselves as wanting to progress this issue have been part of the funded program looking at developing networks around issues of mental health?

Ms Rosenstreich—Yes.

Senator MOORE—Thank you.

Senator BOYCE—I have just had a chance to have a quick look through the format of the LGBT Alliance. You do not appear to have any members who support survivors of suicide or any bereavement support groups.

Ms Rosenstreich—There are currently no such groups, to my knowledge, that work specifically around LGBT communities. Some of the more generic groups informally play that role, and that is part of what we would like to see happening—more capacity building in those sorts of groups that are working holistically and picking up some of that—but they often have no resourcing. They have expertise through experience but would certainly benefit from more support. It can be as simple as working in partnership with organisations already doing this type of work so that it is effective use of the knowledge of each side. But, to my knowledge, there is nothing specific. We do not yet, at least, have a relationship with any organisations working to provide the type of service that seeks to target these communities. It does not mean that it will not happen—for example, we are just starting to build relationships with Suicide Prevention Australia. But it is a slow process and very difficult with one staff member.

Senator BOYCE—Are you aware of an expressed need for specialist support groups for the gay and lesbian community, or the GLBT?

Ms Rosenstreich—I am not aware that that has been articulated as a specific need. Are you aware of anything, Atari?

Mr Metcalf—I can talk a little to that point. To give a little context, I was the researcher and writer of Suicide Prevention Australia’s recent position statement on this topic, which is suicide and self-harm in LGBT communities. Through the consultation that was conducted, that was raised. In the context of a concern around contagion, there can be clusters as suicide as a phenomenon unfolds, and for that reason it certainly came up in the conversations that the reference group had. That reference group was comprised of both GLBT-specific community sector services and also organisations like Lifeline and the Mental Health Council. I think there is a need for that. I suppose this is an issue that has been untouched for so long that the list of needs is this long. But, absolutely, I think that it is important.

Senator BOYCE—That is right. When we first began this hearing I asked whether suicide was always a mental health problem and the answer was no, it is not always a mental health problem. But you have identified, Ms Rosenstreich, the idea that we still have a very clinical focus on it. Am I right in thinking that in the LGBT sector mental health is less of a cause of suicide than it might be within the general community?

Ms Rosenstreich—I would say we can probably assume that causal factors that are separate to sexual orientation and gender identity will be represented in exactly the same way in the LGBT communities as in the rest of the communities. The reason the rates are so incredibly high among LGBT communities is the extra factors that are directly related to those parts of who somebody is or what they are dealing with. I would say it is very much the same as the general population. What we would like to see is rates in the general population improving, including LGBT people, but that we can no longer identify particular high rates or high risks for this population.

Senator BOYCE—I guess what I was thinking was that if mental health was not the primary cause perhaps you are looking at a different way of approaching suicide.

Ms Rosenstreich—Absolutely. Yes.

Senator BOYCE—In the LGBT, too.

Ms Rosenstreich—Yes.

Senator FURNER—With regard to your statistics, how far back can you go in terms of identification? I am particularly interested in Indigenous population and also the rural and remote areas and whether it is possible to break down the numbers in respect of those communities.

Ms Rosenstreich—Around suicide?

Senator FURNER—Yes.

Ms Rosenstreich—We cannot at all simply because we do not have that sort of differentiated data collection. One of the huge gaps in research is really detailed demographic information of the populations we are talking about. To my knowledge none of the studies that are looking at Indigenous people collect sexual orientation data. The mental health survey did but as far as we have been able to ascertain there has been no published analysis of those findings. I do not know why. There could be a number of reasons. The simple answer is we do not know. Would that be a fair assessment?

Mr Metcalf—Absolutely. Of the research that has been conducted specifically into LGBT suicide, it is very difficult to aggregate that by location and by Indigenous status, in part because the sample sizes are often quite small. So the bigger sample sizes are around 5,000, but there are significant challenges methodologically speaking in sampling in such a way that you can actually generalise those findings to a whole population. For that reason one of the core recommendations is that sexual orientation and gender are actually included or there is an option for people to disclose in more mainstream based research into suicide.

Ms Rosenstreich—What we do not know changes over time. What we do know, not through household surveys et cetera but through experience and some qualitative research, is that they are extremely alarming rates. When we have been consulting with Indigenous LGBT people, suicide again and again is the first issue that is addressed. Whether that is visible as suicide or it just looks like somebody drinking themselves to death is another matter. But it is the core issue.

Mr Metcalf—The other difficulty which compounds, particularly in the context of coronial reporting, is that sexual orientation and gender identity are not demographics that are readily observable. You cannot always tell by looking at somebody. In the context of Indigenous suicide I think it may be even more difficult. A lot of Indigenous LGBT people say that when they go back to their communities they have to play a particular role that conforms to what is expected and culturally acceptable. Many of them talk about displacement and having to leave those communities, which further breaks down the connection to kinship and to land, in order to be able to be themselves in terms of reconciling that inner distance around sexual orientation, gender and their Indigenous heritage. It is certainly a doubly compounding situation to be both Indigenous and lesbian, gay, bisexual or transgender.

Senator FURNER—What about sex? Is it identical to what has been demonstrated, that the male population has the higher degree of suicides than female?

Mr Metcalf—Yes. From the studies that we have, that is the case—men who have sex with men or who identify as gay or bisexual. Interestingly, similarly with the broader population trends, self-harm, however, is highest among bisexual women and men. However, transgender and intersex groups are speculated to have the highest rates of suicide. They do not neatly fit into male and female, obviously. Some of them do identify with those categories but many do not. Why that is is perhaps subject to the same, I would argue, phenomenon that we see, so the choice of means and help seeking as core challenges for young men and transgender people.

Senator BOYCE—Do you have more men or women seeking help from you from rural areas? Is there any marked difference in that respect?

Ms Rosenstreich—I am not sure. I would need to find out. I do not think so. We do have member organisations that work specifically in rural areas. Most of them tend to work with young people. There is a real lack generally of services in rural areas. Service provision differs according to the different states and territories. What we do know is that the services that are being provided in rural areas that are visibly targeting LGBT people are tending to be those that are working through a sexual health framework and are tending to be funded through HIV funding. My assumption would be that they are tending to reach gay and possibly bisexual men more than lesbians and certainly transgender and intersex people simply because of the structure of those services. That is simply a reflection of funding frameworks. I would assume that they are probably reaching men more. That is conjecture though.

CHAIR—I have one last question. We also specifically want to consider high-risk groups. It was put to us yesterday by a number of witnesses talking around the high rates of suicide in Indigenous communities that we should have a separate strategy to deal specifically with Indigenous suicides because of the particular high risk and other particular issues. It seems to me from both your submission and your evidence that LGBTI communities also have a number of specific high-risk issues that are not dealt with through the strategy and need particular attention. Would you argue that there needs to be a separate strategy or a separate part of the strategy or that the strategies should specifically identify the high-risk factors that are specific to the LGBT community?

Ms Rosenstreich—Fundamentally I think a specific strategy would be valuable, so long as it does not lead to a generic universal strategy. The reality is that a lot of people are not yet self-identifying et cetera, so mainstream services need to be competent to work around diversity. If it was at the cost of explicit exclusion from a generic universal strategy then, no, I would not advocate for that. I think there would be real value in having a specific strategy as a short- to medium-term approach. That could achieve a lot. It has to be tied to actions ultimately. That is the main point.

CHAIR—It seems to me that the LGBT community is suffering from at least a double discrimination. Then when you are talking about Aboriginal LGBT people you are getting down to multiple layers of discrimination. It seems to me that we need ways of addressing that. I totally take your point about not having it completely separate from mainstream services—generic services and then completely separate services, which are bound to be underfunded et cetera.

Mr Metcalf—May I also add to that point. We touched on before the reliance on clinical and medical models in discussing mental health and suicide, but many of the factors that affect this community and others in Australia lie outside the domain of health alone. There are social determinants that lie with the education sector and the juvenile justice and criminal sector. For that reason I think service coordination and the concept of a ‘no wrong door’ policy is really important—whether you go to a youth service down the road or you call up a Lifeline, you will get to the right place to get the help you need.

CHAIR—That message has come through very strongly in the evidence and submissions. We have gone over time. We go over time all the time! Thank you very much for your submission, your additional information and coming today. I know we have given you some homework, so when you get a chance to do that it would be appreciated.

[2.50 pm]

SHEARER, Mr Mort, National President, Australian Men’s Shed Association

CHAIR—I welcome our next witness, Mr Shearer from the Australian Men’s Shed Association. I understand that you have been given information on parliamentary privilege and the protection of witnesses and evidence.

Mr Shearer—I have indeed.

CHAIR—And we have your submission. I invite you to make an opening statement and then we will ask you some questions.

Mr Shearer—Thank you. I will perhaps just introduce myself briefly first. I have in fact been involved in suicide prevention on a voluntary basis since 2003. I was very involved in founding and leading a pilot suicide prevention network in Port Macquarie under the original National Suicide Prevention Strategy. I then took that model to Wesley Mission, to the LifeForce program, and that became the basis for the LifeForce community suicide prevention networks—and I am so glad to see that that program is continuing and expanding. Through my involvement in suicide prevention, one of our first projects in the Port Macquarie network was to set up a men’s shed because we believed from all the information we had and from our own inquiries that a men’s shed was probably a very effective way to gain access to a very high risk group, particularly older, unemployed, socially disconnected or geographically disconnected males—men with a number of very high risk factors who are extraordinarily hard to access, primarily because they do not access traditional health services. That led to my involvement with men’s sheds—we established a shed there—and it is has kind of moved on from there.

I noticed this morning, listening to some of the evidence, that a couple of major themes came out, ones which we are very keen on. One is stigma, and stigma is an absolute roadblock in suicide prevention. It comes from a number of issues, and it has become a cultural issue now. Men’s sheds, we have found, are a very good way to sidestep the stigma of suicide prevention and mental health and indeed of men’s health, because a lot of men are not keen on pursuing their own health issues. The men’s sheds initially offer just a place to come and do some project work, community work, one’s own work, family work or whatever in the company of other men in a quasi-work environment, but without the pressure of work, so that it becomes a very healing and useful environment. That environment then allows the men to start sharing with each other and start developing support groups, and that also allows us to introduce subtle health messages. We find that men readily take up their own health issues in that environment after they have been in the shed for a short while. So the stigma issue is one we are able to address quite effectively within that particular high-risk group.

Another theme is communities, and communities are very much a part of this whole issue because men’s sheds are essentially community based efforts. They are very much supported by communities. Men’s sheds are accepted by communities because they are an intuitive solution to a problem which women in particular seem to recognise, which is that men do not look after their own health and wellbeing properly.

Communities have responded astonishingly right across the country. We have examples in my own area of the mid-north coast of New South Wales. When we started four years ago, there were three sheds in the area. There are now 14, and every one of them is a community based shed. They have sprung from the community. It is most impressive the way the whole community has responded to the shed movement and to the idea of sheds. We believe sheds are a very cost-effective, practical, community-friendly and, most importantly, male-friendly way of approaching suicide prevention as well as mental health and men's health generally.

Senator FURNER—How do you derive your funding for the association?

Mr Shearer—For the Australian Men's Shed Association the funding situation is quite desperate at the moment. We have had sufficient funding to employ 1.4 people through an auspicing body over the last two years. That funding is about to run out. We have applied to a number of federal government departments, with very little response. We currently have a significant application for seed funding before Minister Snowdon, the Minister for Indigenous Health, Rural and Regional Health and Regional Service Delivery. Because we also have state bodies that look after the state issues, we also have some funding applications before DEEWR to fund some of the state bodies.

Senator FURNER—What sorts of lessons are you getting out of the other initiatives in New Zealand, Ireland and the USA?

Mr Shearer—We are giving them the information at the moment; they are very much in their infancy. The Irish government has recognised the issue and sent out a representative to our national conference in Hobart in August, at which we appointed out first national board. To update some of the figures from that, we have, incidentally, just enrolled our 400th shed across Australia. So it is a rapidly-expanding movement.

Senator BOYCE—Did I hear that the most recent one was in Strathpine in Brisbane?

Mr Shearer—No, that one has been with us for a little while. The 400th one was in North Queensland.

Senator FURNER—You identify women as being some of your strongest supporters. Why is that the case?

Mr Shearer—I believe it is because women genuinely understand the issues behind men not looking after their health and wellbeing, recognising the damage that it is doing not only to the men but also to the women themselves, to their families and to their communities. It is mothers, sisters, partners, wives—they are the people who send probably the majority of our members along to sheds.

Senator FURNER—As a strong believer in equality, do you think we will see a time when we will have women integrated in sheds as well?

Mr Shearer—No.

Senator BILYK—We do have them in Tasmania.

Senator BOYCE—Inclusive sheds?

Senator BILYK—Yes, they have them in Tasmania.

Mr Shearer—There are one or two who have tried that, yes, but the essence of sheds is primarily that it is a male-friendly environment. Once we introduce women into that environment, the dynamic changes dramatically and it loses that male intimacy and bonding which is such a valuable part of the whole process. The real objective of sheds is to get the men socially connected. It is not to build things. It is not to hammer nails into things. It is not to saw things. It is to get men talking to each other, reaching out and developing support groups. That is what saves their lives.

Senator FURNER—I am interested in your comment about a ‘boss-free zone’. How does the delegation of duties such as cleaning, cooking and everything else in the shed happen if it is a boss-free zone?

Mr Shearer—Voluntarily. Running a shed obviously requires a degree of tact. Also, the coordinator of a shed, whether he be paid or be voluntary, is probably one of the most important people in the shed because he needs to be someone who has, obviously, the ability to keep the men safe. A prime requirement is that the men must be physically safe. Then they must also be emotionally safe. We must set a happy environment in which men are encouraged to develop these relationships and to develop the concept of thinking about their own health and well-being as well as actually making things. That is the thing that ostensibly is the reason for their being there. He must also be someone who can look after the housekeeping. So it is a pretty taxing environment.

Senator FURNER—We are moving to a society now with an ageing population. We are living longer. Over time the government has increased the retirement age to 67. I understand the opposition wants to look at possibly 70. Do you see that having any impact on the operation of the men’s sheds?

Mr Shearer—Perhaps the men who are unemployed and coming to sheds might grow a little older. Essentially, a lot of the men coming to sheds also have other issues, like having lost families, having lost their own mobility and their own health, in some cases. We have a lot of special needs people who come to sheds. It is quite a mix. We also strongly encourage mentoring of young people, and we are very keen to have young people come along to sheds. Unfortunately, that immediately raises issues of child protection, which we are very mindful of. We are developing national policies on that as we speak. There is a range of people who come to sheds so it will not have a dramatic effect but it will certainly have an effect.

Senator FURNER—You speak about learning opportunities in computing, cooking, nutrition and yoga. Do you have data on how many of those learning skills people would pick up and then integrate back into the workforce?

Mr Shearer—We do not. We have 1.4 people handling 400 sheds so we do not have the resources to gather the information at the moment. However, Professor Barry Golding from the School of Education at the University of Ballarat produced a 2007 paper on learning in the community. He particularly concentrated on men’s sheds. That led to his becoming one of the leading researchers on sheds. He very strongly endorsed and confirmed the ability of men of mature age, let us say, to continue learning and the value of that learning to themselves and to the community.

Senator ADAMS—I come from a rural area in Western Australia, and this has been a godsend. I have been talking this morning about the problems of men aged 50 years and over trying to cope financially with a farm and all the other issues that go with it. If they happen to retire into the town and their offspring are on the property then they are on a pension but they really have nothing to do. The value of the mentoring that these people can do, especially with the young high school people and Indigenous youth, is invaluable. Some young people do not want to go on to high school but are prepared to stay on if they can have hands-on work. Having a number of older people who have those skills and who are able to hand them on makes a huge difference. This has evolved out of the men's shed but these people have skills that they can use to help the community.

Mr Shearer—An important component of men's sheds is learning new skills. Men can come into town from their properties and start to learn new skills such as computing. A lot of the older men do not have those skills at this point. That also puts them in touch with their distant families. Another part of that whole process is the geographic isolation, which is just as bad as the social isolation. It attracts men to the shed when they come into town because they can instantly start to build a community of support people for themselves. In rural communities there has been some very strong support for sheds. In Western Australia we held an informal conference at Mukinbudin late last year, just after our national conference in Hobart, and it was spectacular in the amount of support that came from outlying communities and in the support this tiny town of Mukinbudin gave to host this conference of about 200 people. The week before last I went out to Wellington in western New South Wales where there is a new shed starting in Gulgong, which is about 70 kilometres away. Gulgong did not have anywhere big enough to host something, so the guys at Wellington shed said, 'We'll hold an expo day for you to celebrate the opening of the Gulgong shed'. There were 30 sheds from as far away as Bourke and Lightning Ridge and over 200 people turned up. The response was astonishing. This is why I say the communities are strongly picking this up, they are recognising the value of these sheds as a very valuable part of the community. It is my personal belief that sheds belong up there with Red Cross and CWA and Lifeline and all of these organisations as part of every caring community, and that is one of the things that we are working towards.

Senator BILYK—Mr Shearer, you might need to take this question on notice. Do you have any statistics on how many men might access and use the sheds across Australia?

Mr Shearer—That is very much something that we would love to be able to put together, and because we are now starting a national insurance scheme we are going to be able to collect some of this information. But at the moment our best estimate is that we have 400 sheds involved with us taking an average of about 50 men. The size of the sheds varies from the tiniest of about 10, the average shed is 40 to 60, and then there are a couple of sheds that are around 150 to 200. That gives us an average of 20,000 men across the country, which is a lot of men.

Senator BILYK—It is. Once again, you probably do not have the stats on this but maybe it is something you can think of once you start collecting the stats that you need for insurance purposes: the use of migrants—

Mr Shearer—The use of?

Senator BILYK—Do you have any idea how many migrants might come in? I was reading somewhere recently about the suicide rates of migrants in Australia, and in particular in South Australia. I was just wondering if you manage to get to men out in the migrant community, to get them to visit men's sheds and use the facilities.

Mr Shearer—At this stage we have no hard information on that and that certainly is—again, we would like a breakdown of the types of men who are attending sheds, particularly looking at Indigenous men. But of course Indigenous men are perhaps a different issue because they tend to get most value out of having their own cultural environment, therefore they tend not to be quite as frequent visitors to the existing sheds. We are looking very much at the establishment of specifically Indigenous sheds so that we can provide that cultural support. We have very little information on migrant numbers at the moment, but it is certainly one of the things that we would like to have the resources to be able to chase up and tease out some figures and tease out some sensible conclusions as to what the needs are of the groups that we are attempting to serve.

Senator BILYK—How do men in general learn about a men's shed being available for them to go to in any particular area?

Mr Shearer—Community information. In my own particular area, for example, we mercilessly beat the media drum regularly because it is not only letting the men know, it is also eliciting support from the community because of the lack of funding at all levels of government. We rely very strongly on community funding, and therefore we make as much noise as we can so that we can encourage community support, not only in dollars but also donations. For example, in our shed we have a well set-up workshop and we have only bought two tools; all the rest have been donated. So this is the kind of thing that we are telling the community about and, in the process, we are also recruiting members—as I said, often through the women.

Senator FURNER—Who would be your major sponsors in that respect, the donations of tools et cetera?

Mr Shearer—I guess right at the top would be the service clubs—Rotary, Lions, Freemasons; they are very strong supporters of the whole shed movement. There are also some businesses. When we started our shed in Port Macquarie we had a very gratifying response from businesses who supplied us with a range of goods so that we could set up fire protection, for example, and a whole range of tools and equipment and safety equipment for the men and those kinds of things. So it is across-the-board support—the churches and some of the service providers are very supportive of what we do. And ordinary people come out of the woodwork; donations just sort of appear in the mail, which is just wonderful.

CHAIR—How much money do you need to run the organisation effectively?

Mr Shearer—To run the national organisation effectively at the moment, we put in an application for $800,000 a year over three years. That is to set up the national secretariat so that we can start to gather some of this information that you are asking for because we need to be able to prepare proper evaluation of what we are doing. We also believe we need to demonstrate to government very clearly just how much of the load we are taking off medical services and social services by doing what we are doing. We believe that is very significant. We are working with a couple of university studies. I would like to bring some accounting firms in who can put some numbers around this so that we can demonstrate the genuine saving to all levels of government through what we are doing. That is at the national level, and then there are also the states.

CHAIR—Have you done the breakdown for that?

Mr Shearer—Yes, it is a similar amount of money.

CHAIR—For each state?

Mr Shearer—No, It is a similar amount of money for the national organisation and for the group of state associations because they do not need the secretariat; the national body looks after that.

CHAIR—Thank you very much for your submission and for your time today. It is much appreciated.

Mr Shearer—Thank you.

Proceedings suspended from 3.13 pm to 3.27 pm

HAWDON, Mrs Kathleen, Private capacity

CHAIR—We will resume. Mrs Hawdon would like to make a statement because we will not have time to ask her any questions.

I know you have listened to me doing the introduction around parliamentary privilege and the protection of witnesses and evidence. You were not on our program, but you would like to make a statement and we felt very strongly that we would like to hear from you, so we have got a short amount of time. I also understand that you would like to put in a written statement a bit later as well. So I invite you to talk to us.

Mrs Hawdon—Thank you for the opportunity. I am here with Tony from Speranza, which supported us with the tragic loss of our son.

I just wanted to demonstrate the current inadequacies in our psychiatric hospitals. We lost our dear son, Ben, in October 2007 at age 29. He had been suffering with chronic schizophrenia for over 13 years and had many admissions to hospital. He suffered from suicidal ideation over a long period of time.

In 2007 he had a significant relapse, and within the weeks prior to admission had expressed to the area health team which was looking after him feelings of being at risk of self-harm. He was scheduled to the Cummins Unit at Royal North Shore Hospital in October that year, where he tragically took his life while on one-hour unaccompanied leave.

He was transferred from the acute to the subacute section within that unit within 24 hours before he was authorised leave. He was not assessed on the day he died. There were no nursing or clinical observation notes written for our son on the day he died. He was told by his case manager the week before he died that his friend, who had been an inmate of the Cummins Unit, had taken his life. He attended a magistrates hearing the afternoon he died and was significantly disturbed by the outcome of a further two weeks hospitalisation.

After the hearing he was calm and asked the registrar for one hour unaccompanied leave. Within 45 minutes minutes of leaving the hospital, he took his life by jumping from the Strathallen bridge at Northbridge. It was revealed at the coronial inquiry that the registrar had not seen the protocol for suicide risk management. Our son was the third suicide shortly after discharge in three weeks. In a three-week period our son was the last of three patients that had been looked after by the Cummins Unit to die.

We need accountability to expose the inadequacies of our present system. The present system is that the hospitals investigate the hospitals. This leads to virtually no accountability.

CHAIR—Thank you very much. I understand that this is the first time you have appeared before a committee of this nature. Thank you for sharing that information with us. We would welcome any written material that you would like to submit to us later on.

[3.32 pm]

DODD, Mr Peter, Solicitor, Health Policy and Advocacy, Public Interest Advocacy Centre

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

Mr Dodd—I do understand.

CHAIR—I invite you to make an opening statement and then we will ask you some questions.

Mr Dodd—I understand that the committee is looking at the whole range of issues around suicide prevention, and in the PIAC submission we did not even attempt to deal with that wide range of issues. Our submission focused on the importance of the coroner in terms of suicide prevention in Australia and how the coroner's role could be enhanced in relation to suicide prevention.

Last Monday in Melbourne there was a meeting of the national coronial reform working group. There were 45 participants from all over Australia. They came from community legal centres, legal aid and Aboriginal law services. They looked at the general issues of how the coroner's role could be enhanced in the prevention of death, and of course one of the very important areas there is the prevention of death by suicide. Many of the submissions that have been made are similar to submissions that were adopted by that group. That group decided to go forward and take a strong role in terms of advocating for those reforms. PIAC believes, as that group believes, that the coroner's role is vital in terms of the prevention of preventable deaths is Australia, and again suicide prevention is a very important factor in that equation.

Senator BILYK—Mr Dodd, I am not sure whether you will be able to answer some of my questions but, if not, perhaps you can direct us to where we can get answers. What is the criteria for a coroner to determine that a death is by suicide?

Mr Dodd—Coroners generally look towards what is called the manner or cause of death. That is what is in the New South Wales legislation.

Senator BILYK—Is that Australia wide?

Mr Dodd—Generally. There is new legislation in Victoria which has enacted some of the things that PIAC is calling for in this paper. This might seem to answer your question in a roundabout way, but I think it will answer the question. We have said in this paper that there needs to be reform to the role of the coroner, especially in relation to making recommendations. At the moment, 'manner and cause' sometimes restricts the coroner in terms of making broader recommendations about preventing deaths like suicide. In the paper I refer to New Zealand legislation which gives the coroner much broader powers. I think that is very important because, if the coroner does have those broader powers, the coroner can look at broader issues and make recommendations. That is a vital area of law reform. As I said, the Victorian legislation goes some way towards that, but we still have that narrow, restrictive view of what the coroner can make recommendations about.

Senator BILYK—Can you clarify something for me? We heard earlier today in evidence that a death that had been by suicide was recorded as blunt trauma injury or multiple blunt trauma injury—I cannot remember the exact definition. Would that be common, or would a coroner normally put suicide as the cause of death?

Mr Dodd—The coroner would normally make a comment about the manner and cause of death. If it was self-inflicted and that was the coroner's finding, that is what they would put. If it was not, they might put another cause or that it was uncertain. I would expect that, normally—

Senator BILYK—I am sorry, I am just not clear on the exact process of who fills in what form so I am seeking clarification. I am not trying to trick you at all. Would a doctor put that?

Mr Dodd—When someone dies, often an autopsy is done by a forensic pathologist, and that would have their opinion about the cause of death. There would also be a death certificate, because there is a death certificate for everybody, and that come to a conclusion. The police would normally investigate if it is referred by the coroner, and they would come to a conclusion. If it is decided to have an inquest, the coroner makes a finding as to the manner or cause of death. I do not know where that finding came from.

Senator BILYK—For obvious reasons I cannot be too specific about the case.

Mr Dodd—It sounds as if it might be something on a death certificate rather than from a coroner. If a coroner is unable to find a view, they will come to an open finding. If they are able to come to a view, they would come to a view that the death was self-inflicted.

CHAIR—As I understand it, it was on the death certificate.

Senator BILYK—Was it? Thank you.

Mr Dodd—That is just an opinion. In fact, people get caught up with that. That is quite often done on the run and is sometimes not accurate in terms of the cause of death.

Senator BILYK—Yes. I understand that it did cause some stress to the family. What if there is doubt about whether it is a suicide or an accidental death, for example? Would the coroner leave it open?

Mr Dodd—If the coroner cannot make a determination, they come to an open finding.

Senator BILYK—I know one used to be able to find statistics on suicide rates in Australia, published by the ABS. Is there anywhere else that you know of where we can statistics from?

Mr Dodd—You have raised a very interesting point. I cannot tell you about ABS type statistics, but there is a national coronial information service, which has been around since 2000, which is some sort of record of all the coronial inquests that have occurred in Australia since then. There is a problem in that that is not very accessible. You would certainly be able to access it. It is a paid service. Some of the good news we got on Monday is that AustLII—the Australian Legal Information Service, which is on the internet—will in future have all the coronial decisions in Australia. But at the moment that is one of the problems: there is nowhere that you can go and easily access, let’s say, all the coronial decisions in Australia from all the different jurisdictions. That does provide not so much statistical information but a wealth of information about preventable deaths by way of suicide in Australia.

Senator BILYK—You mention in your submission ‘the importance of coroners’ inquests in the prevention of suicide in Australia as well as to highlight the need for law and policy reform’. How do you see coroners’ inquests actually helping to prevent suicide?

Mr Dodd—I think the very important thing is that the coroner, in all jurisdictions, has some power to make recommendations. As I said earlier, that is somewhat restricted and we want it broadened, but that power to make recommendations is very, very powerful. For example, the coroner in Great Britain does not have that power, but in all Australian jurisdictions and in New Zealand the coroner has that power, which means the coroner can make recommendations about how to prevent suicides.

Senator BILYK—Can you give a couple of examples?

Mr Dodd—The example that I will give—and I even have a copy; it is referenced in the submission—is the inquest into the death of Scott Simpson. That was in New South Wales. Scott Simpson committed suicide in the New South Wales prison system, and the coroner made a range of findings. In particular they were about segregation in New South Wales prisons, but she made a whole range of other recommendations. There has not been a public response to all of them, unfortunately. That is a very good example, and I have a copy of that. I can certainly provide it.

Senator BILYK—That would be handy, yes.

Mr Dodd—It is a good decision and it certainly is comprehensive in terms of both the findings and the recommendations of the coroner.

Senator BILYK—I think things such as the removal of hanging points in jails have come about as a result of coroners’ recommendations too.

Mr Dodd—Yes. The Aboriginal deaths in custody royal commission also highlighted that. Again, that is a continual problem that coroners highlight.

Senator BILYK—Yes. Thank you.

Senator BOYCE—We took evidence in Queensland yesterday from the children’s commission, which looks at the prevention of deaths of children and adolescents, and we discussed the issue of the ABS figures and the coroner’s findings. In fact, in Queensland the commission had identified well over 50 per cent more deaths by suicide than had appeared in ABS figures. As I understood what the woman from the commission told us yesterday, in Queensland, in the case of a hanging, the coroner would enter a finding of ‘accidental hanging’ or ‘hanging’, and if the finding was ‘hanging’ then you would assume that it was a suicide. Would other coroners use a similar way of distinguishing between an accident and a suicide?

Mr Dodd—I think they generally do. For example, in this matter there was a finding, about Scott Simpson, that he deliberately hanged himself. There is no equivocation there. But the coroner has to be satisfied and if there is any doubt then perhaps he or she uses language which reflects the level of satisfaction they have come to. So if there was a doubt about whether it was deliberate then maybe the coroner would not have come to that final conclusion.

Senator BOYCE—That is slightly different from what appears to be happening in Queensland. We appeared to be being told, ‘If it doesn’t say accidental, assume suicide,’ so to speak.

Mr Dodd—There is no sign of that being reflected in New South Wales.

Senator BOYCE—My other question relates to the comments you have here regarding whether a government response to coroners’ recommendations is mandatory or not. Was that discussed in your working group? You have pointed out here that the Hon. Bob Debus had mentioned this being something that was going to happen. Has there been any follow-up yet that you are aware of?

Mr Dodd—The answer is: yes, it certainly was mentioned in that working group, and that is one of the major recommendations that is going to come out of that process. The legislation and practice varies from state to state. Victoria does have legislation that mandates—

Senator BOYCE—Victoria and the Northern Territory, I think you told us. Are they the only places still?

Mr Dodd—In South Australia it goes through the parliament, but only if it is a death in custody. And in New South Wales—despite the fact that there was recently a new Coroners Act—there is not any legislative provision, but there was certainly a statement by the Attorney General to the same effect, about process. So there is progress on that issue but there is a long way to go. PIAC and the national group would want national uniformity on that point.

Senator BOYCE—My follow-up question is: if we have state governments responding to recommendations, what would be the mechanism for keeping some national consistency and uniformity?

Mr Dodd—That is an interesting question. Apart from uniform legislation, which I think is a long way away—

Senator BOYCE—Let us get to that one first!

Mr Dodd—It is a long way away. I think that would be preferable but, seeing as we have not got that, I suppose it would be just a general commitment from state governments that, as a national principle, there should be mechanisms where there are proper report-back provisions from coroners’ recommendations.

Senator BOYCE—One of the problems could be that state governments might respond but in very different ways, which could then leave us with a bigger mishmash than currently exists.

Mr Dodd—Senator, you would understand—

Senator BOYCE—One can but try!

Mr Dodd—that we can only ask for a government response. What happens if we do not like that response is a different matter. There was some discussion—and it is an interesting point—on how much of a role a coroner might have in responding to the government's response, and on whether the coroner should have a role in perhaps asking questions or taking it further if there is some feeling that the government response does not appropriately respond to his or her recommendations. But that is something for future thought.

Senator ADAMS—My question is about how long a coroner's report takes after an autopsy. This is where families suffer. It is hard enough with a death such as one from suicide, but then they have to wait and wait. This seems to be one of the biggest issues that I have come across with the coroner. Why does it take so long?

Mr Dodd—I think the answer as to why it takes so long is that sometimes the police investigation takes a long time. But you are quite right—it is not satisfactory. PIAC has raised it in this submission. A problem in New South Wales is that there is a lack of forensic pathologists so that there is a huge delay even in people getting the autopsies, let alone getting on to the inquest. But the delay in inquests is definitely something that the judiciary should look at, because you are quite right—it has a devastating effect on families. People are grieving and yet they have to wait for such a long period of time before it gets to the inquest.

I am still dealing with an inquest in which PIAC is acting for a client, and the death occurred in mid-2006. There have been some delays lately which are partly not part of the process. There was a reopening of the inquest, but nevertheless that sort of delay as a general thing is not appropriate.

Senator ADAMS—There is sometimes a delay when releasing a body so that a funeral can be held. Often people do not realise that when they agree to an autopsy. They think they can go ahead and organise the funeral service because they want to get going, get things over and be able to clear the decks a little. They find that the body is not released or there is some mix-up with that. It is another thing that is so devastating for a family to have to put up with.

Mr Dodd—I think there is a balance there. We want these matters thoroughly investigated. There has to be some time for the police or whoever else is investigating.

Senator ADAMS—Perhaps it is not explained at the time that this process is going to take time. People just do not know and they go ahead with arrangements and then they find that they cannot go ahead with them, like putting death notices in the paper and things like that. This information needs to be somewhere in the system. When something like this happens, the family should have the processes explained very carefully to them.

Mr Dodd—Something else that has come out of the reform group is that we are advocating for better communication with families, especially with Aboriginal and Torres Strait Islander families, and people from non-English-speaking backgrounds. There is a definite need to improve communications. The coroner's courts in New South Wales and the rest of Australia have made advances in this area but I still think there is a lot more work that can be done. As you said, it is a real trauma for people to go through the process. It is a trauma to go through the investigation. It is a trauma to instruct the solicitor and it is a trauma to go through the actual inquest because they have to relive it every time. There has got to be more effort in this area to work with families.

Senator ADAMS—Good; I am glad we have got that on record because it is a very important.

CHAIR—I have got a couple of questions; a bit of a different field. Issues around privacy have come up a number of times from witnesses who have had difficulty getting access, particularly parents, to information about their children who have either been in hospital or in court. It came up yesterday, today and when we were in Canberra about the balance between the privacy of individuals and the need to get access to information and provide some support. Have you been involved in that issue specifically around suicides; and do you have an opinion on that?

Mr Dodd—It is a constant problem. The New South Wales parliament has tried to address it in the most recent changes to the Mental Health Act in New South Wales—and I am talking about 2007—where designated primary carers have access to some information. I think that is an attempt to find that balance because it is a balance that has to be struck. There is no doubt that patients have rights and that has to be balanced with the family's rights and the welfare of the patient, the consumer or whatever you want to call those people. Yes, we have come across that problem and, yes, it is one where it is difficult to find an answer. I am not sure whether the New South Wales legislation finds the right balance but it is an attempt to do that, partly because the legislation is a bit ambiguous. It does provide an opportunity for primary carers, as they are called in that legislation, to participate in the discharge planning in particular and get certain pieces of information about the patient.

CHAIR—Do you have experience in other states?

Mr Dodd—I do not know about other states. From my knowledge there is not similar legislation in other states, but I would not be absolutely sure about that.

CHAIR—It certainly came up in Queensland and it has come up in other submissions as well.

Mr Dodd—It is a constant problem, as I said, to find the right balance. Privacy is an important principle.

CHAIR—I agree. It is a really delicate balancing act between ensuring privacy but also ensuring people get care.

Mr Dodd—The existing privacy principles do have exceptions for providing information in certain emergency circumstances.

Senator BOYCE—It is how you choose to interpret and use those provisions that can be the issue.

Mr Dodd—I think on that point it is not in any way consistent and that is part of the problem.

Senator BOYCE—It tends to appear to be on the whim or the understanding of an individual rather than according to any sort of plan.

Mr Dodd—I think sometimes hospitals and the medical profession use privacy as a shield not to talk to people.

Senator BOYCE—That is where I was about to head with a slightly more general question. Has your organisation been involved at all in the issue of the treatment of people with mental health issues, particularly people who have attempted suicide, by hospitals and other professional health organisations? We have had evidence around stigma, certainly brusque and, in one case it would seem, inhumane, treatment of people in hospitals who are at risk of suicide.

Mr Dodd—That is a very broad area. Yes, we are involved.

Senator BOYCE—I wondered whether your group as an advocacy group on public interest issues had been involved.

Mr Dodd—Yes, the inquest that I referred to that is ongoing—so I have to be careful about what I say because the coroner has not made his determination yet—is about a patient who was trying to get admitted to hospital, who was not able to and who unfortunately killed himself. That was the one in 2006. It has raised a whole range of issues about alternative care for people who are in acute stages of their mental illness and just how people are treated in their community when they are in an acute phase of illness. What we have said, I think it is included in this submission, is that we have to look at some sort of alternative, if people cannot be hospitalised, for people who are at risk to themselves in an acute phase of illness. I do not think anyone would want to go back to the old days of institutionalisation but I think there is a group out there—

Senator BOYCE—I think perhaps we have had one witness who might not have thought that was a bad idea!

Mr Dodd—There are probably not too many people, but a significant group of people who seem to fall through the cracks.

CHAIR—We have been talking about the step up/step down approach and more facilities to enable that. What you are talking about fits into that category as well.

Mr Dodd—There are people who probably cannot benefit from long hospital stays but just need protection from themselves at particular points and perhaps some long-term rehabilitation rather than intense hospitalisation. The system does not provide that certainly in New South Wales.

Senator BOYCE—You spoke earlier about hospitals using the Privacy Act as a protective mechanism. Why do you think that is? Is it about time? Is it due to concerns about what their duty of care might mean?

Mr Dodd—I think it is all those. I think that it is about time, and I think there is a misunderstanding about what restrictions there are about privacy. One of the points that always intrigue me is that people will refuse to listen to people's information—in other words, they will say: ‘We can’t listen to you. We can’t hear what you’re saying because of privacy.’ That is nonsense.

Senator BOYCE—So, if I am looking up my son or my daughter, for instance—

Mr Dodd—If I see my son or daughter do certain things, I am not restricted by privacy from telling the hospital about that, and yet people use it as a shield, as I say, to stop that. Certainly they might not be able to tell that person the consequences of that and how they are going to treat them or what their diagnosis is, but they can receive that information without breaching any privacy legislation. Unfortunately, because of that Privacy Act perception, people do not have any dialogue with families at all. I do not know whether there was a golden age where people did have more dialogue with families, but it certainly does seem to be a problem that families and friends encounter still in 2010.

CHAIR—Thank you very much for your time here and your submission. It is very much appreciated. You are tabling that document?

Mr Dodd—Yes, certainly, you can have a copy of that.

CHAIR—That is the findings—

Mr Dodd—In Scott Simpson.

CHAIR—Yes, thank you very much.

Mr Dodd—Thank you for your time.

[4.02 pm]

ALLAN, Associate Professor John, Chief Psychiatrist, NSW Health

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

Prof. Allan—I work in the Mental Health and Drug and Alcohol Office. Today, just for a very short time, I am the director of mental health, as Mr David McGrath is away. He sends his apologies.

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

Prof. Allan—Indeed.

CHAIR—As you are a departmental officer, we will try not to ask you to give opinions on matters of policy. Sometimes we slip up, and then you just say no. This does not preclude questions asking for explanations of policy or factual questions about when and how policies were adopted. We have your submission. I would like to invite you to make an opening statement, and then we will ask you some questions.

Prof. Allan—Thank you very much, and thanks for the opportunity to speak to you in relation to the New South Wales views on our vision for suicide prevention in New South Wales. I want to state at the outset our commitment to improving the mental health and wellbeing of all people in New South Wales. You have our submission. That was a whole-of-government response to the inquiry. It was a collaborative effort. It includes input from NSW Health, including the area health services; the Department of Premier and Cabinet; the Department of Justice and Attorney General; NSW Transport and Infrastructure; the Department of Education and Training; the Department of Environment, Climate Change and Water; police and emergency services; and the Department of Human Services. I guess that is really part of the way we see a whole-of-government, whole-of-community response to suicide prevention. It is obviously a very complex issue, and I will not repeat many of the things that you have probably already heard from other people. I will just stick to what we are doing.

Probably it is important at the outset to say that at the moment we are in the middle stage of reviewing our suicide response strategies, and we will be looking for a new plan. In 1999, the New South Wales government released the 10-year whole-of-government suicide prevention framework, which has driven our response for the last 10 years. There has been an increased investment in capital works to enhance the capacity in emergency and acute cases, including those at-risk people. So, from our point of view, in terms of total expenditure on mental health, things are at a record level for us. I can give you those figures or table them later.

We have had 421 new emergency beds and we have established nine psychiatric emergency care centres. Those are specialist emergency care centres in hospitals to look at acute care for people. We also have a program of emergency mental health services for people in rural areas. Where we do not have those hospital based services, we might use telemedicine and other things to have a wide-reaching access service for people. We have also put 50 clinical nurse consultant positions in emergency departments so that we have an emergency response, so that there is somebody with mental health training always available in the ED in the hours that they are there, and we have a 24-hour system of access for people as well.

Senator ADAMS—Is there a separate triage for people with—

Prof. Allan—Everybody who goes through an ED gets a separate triage. Everybody with a mental health or physical or other issue should be triaged.

Senator ADAMS—Yes, I realise that.

Prof. Allan—That will get them into the ED level triage. It might be that the mental health nurse would be a point of call for that triage. We would actually be expecting everybody to get a medical officer assessment—as everyone should get in an emergency department—but they may want an early involvement of the ED nurse because it might be good for a good assessment, liaison or whatever, and that person might then work with the mental health doctors on call to provide that service. Does that make sense?

CHAIR—Okay. We will come back when we go to questions. Please continue your opening statement.

Prof. Allan—I guess the main thing for us is that the suicide prevention objectives are really integrated into all of our programs. We do not, in one sense, have a specific suicide prevention program; we have many programs that are aimed at building resilience in the communities and improving the mental health of people. I will just list some of those programs, but you can come back and ask me about those. From our point of view, the earlier we start doing things for people, the better we see their mental health in their lives, the more likely we are to be able to prevent suicide.

We have a Families First program and a Safe Start program from our screening for depression of all women during pregnancy and the postnatal period so we can get support to at-risk families and try to do something about that for them. We have School-Link, which is a statewide framework for child and adolescent mental health services. Schools and TAFEs work together to promote mental health and prevent mental health problems. We have recently put out the New South Wales Community Mental Health Strategy with programs for supported accommodation in our Housing and Accommodation Support Initiative, called HASI, in New South Wales to ensure better quality of life for people to live in the community. We have community development policies under the New South Wales Aboriginal Mental Health and Well Being Policy to enhance individual and community wellbeing and safety. We also have the Drought Mental Health Assistance Package, which has been very successful in terms of capacity to support rural workers and farmers in what have been very difficult times for many people in rural New South Wales and which has enhanced the pathways to care.

We have been working on skilling our workforce across the government and mental health services. Some of the things that we see as really important are mental health first aid training across a range of government agencies to improve first responses for people outside the mental health field, and risk assessment and discharge planning policies for the health system to enhance our clinical capacity and look at the continuity of care. We recognise that, in the clinical area, that period of time around admission to hospital and just leaving hospital is the highest risk time for people attempting suicide, so we are looking very closely at that. There is a clinical governance system and a review of all suspected suicides which involve mental health patients. We are looking for systemic key learnings on that, and that is something that I lead in the state. Also, there is our specialised training for front-line staff outside Health, like ambulance workers, youth officers in juvenile justice centres and the new police mental health intervention service.

I will just add a quick word on a new strategy before I finish. Simultaneously with this inquiry happening, the New South Wales government has been developing its new whole-of-government suicide prevention strategy for the next five years. The strategy is aligned with the national LIFE Framework, which is a recommendation of the Fourth National Mental Health Plan and a recommendation with the Commonwealth. We are emphasising the importance of early identification, building resilience and wellness of both individuals and the community and supporting a community of practice and expertise.

So we have adopted the directions of the LIFE Framework, and I will just read them out. The LIFE Framework has five areas of interest. Because we have done some extensive stakeholder consultation, from the feedback we have received, our areas of interest do not sound exactly the same but they are in fact the same areas, with one added. They are: improving the evidence base and understanding of suicide prevention; building individual resilience and the capacity for self-help; improving community strength, resilience and capacity in suicide prevention; taking a coordinated approach to suicide prevention; providing targeted suicide prevention activities; and, lastly—a big feature of the Fourth National Mental Health Plan—implementing standards and quality in suicide prevention, because I think that the evidence about what we have been doing has been lacking in the past. Obviously, we are building on our previous experiences. We have had two stakeholder forums and we are preparing an exposure draft of our strategy which we hope will be going out for public consultation early next month. We look forward to providing you with a copy of that draft when it is finalised. I think that is probably enough to start with.

CHAIR—Okay. Thank you. Senator Moore.

Senator MOORE—Professor, one of the issues we have talked about is targeted services. I think just about every submission talks about the need for coordinated services, which is one of the ideas, and also targeted services, because, while the general issues of mental health and the need to save lives go across the board, particular groups have special needs which must be addressed. Has your policy identified the target groups in New South Wales?

Prof. Allan—Yes, indeed, we have.

Senator MOORE—And what are they?

Prof. Allan—Obviously, for us, young people are a particular target group, and in fact our work has shown that older people are at high risk as well. Naturally, the Indigenous community are a No. 1 target for us, and we recognise that people who come from a culturally and linguistically diverse background are overrepresented in our statistics as well. Of course, the issue of targeting around age and gender is one that we can talk about. More women attempt suicide, but more men complete suicide. Sometimes you can get to a point where you have got more target groups than people outside of those groups. Our view is that, yes, we do have to target particular groups but we also have to look at the whole of community.

Senator MOORE—What about gay, lesbian and transgender people?

Prof. Allan—We have identified that in our submission as well.

Senator MOORE—It is a targeted group in New South Wales?

Prof. Allan—It is targeted group for us, yes.

Senator MOORE—Good, because in the national strategy and also in the fourth national plan it does not seem to me that that group has been effectively identified and—

Prof. Allan—It would be very difficult in Sydney not to do that—

Senator MOORE—I hope so—

Prof. Allan—And it is being done.

Senator MOORE—It is just one of the issues at the national level that we have to address.

Prof. Allan—I have got it in my paper somewhere, yes.

Senator MOORE—The other issue is coordination of services, and that has certainly been an ongoing aspect of the evidence we have received. Is there anything that you can share with us about the way that the New South Wales government is looking at improving coordination at the state level?

Prof. Allan—I think there are two aspects. One is, just from our point of view, the services that we run. We have identified particular coordination issues in hospital and community services. So, even in the state run services, there are still issues around communication. In particular, we have identified that seven-day discharge point as a time for doing that. It is probably worth speaking about that as an aside. One of my sad tasks is to review all the documentation around suicides in our services, and it is obvious that that discharge time is the point at which 70 per cent or so of suicides happen, so for us that is a very serious point of coordination. We are looking at a couple of things. One is that follow-up rate. We think that that seven-day follow-up rate has been quite low. We are targeting that as a major indicator, and that will actually be on the chief executive dashboard, as it is called—the four or five mental health indicators that they have to look at to say whether a service is going well or not—and we have set some targets around that. It might sound modest at the moment, but we have set a target of 70 per cent of people being seen at the seven-day follow-up. That is by our services, and that will not include those people seen by GPs or other means of follow-up. So we are looking at getting that coordination there.

For us, the internal coordination is one thing. The second aspect of the coordination that you are talking about is coordination with community services, general practitioners, non-government agencies and other support groups. There are two things with that. One is that obviously we have formal programs throughout the areas with various general practitioners and other NGOs, and we sponsor a large NGO program and so on. We also see that as a matter of education. Part of that is really around when you are doing a discharge planning exercise or what we are actually now going to call a transfer of care exercise where you think about it as something other than just discharging or getting rid, so you are actually placing a responsibility on one person to another. There is how you do that sort of scanning to determine what are the appropriate follow-ups for people. Nobody in this country could be unaware of the healthcare debate and the issue about the divide in the way that we do that. Hopefully, we will also be part of that reform.

Senator MOORE—I think the goalposts have changed today.

Prof. Allan—Yes.

Senator MOORE—I am not across it all yet.

Prof. Allan—I think we are all twittering away on it. I have actually been out working and I have not had a chance to read it. I think that is a very important point.

Senator MOORE—I refer to the aspect of follow-up care. I have been through the programs that the federal department has funded, one of which is looking at a trial in a community group with a quite structured follow-up for people who have been in service. In your plan, and I know that it is not final yet and that you are still doing it, you are looking at a seven-day follow-up for your services, so that includes hospitals?

Prof. Allan—Yes, and emergency departments.

Senator MOORE—And emergency departments.

Prof. Allan—All kinds of emergency contact.

Senator MOORE—What about mental health services? What about the general public based mental health services?

Prof. Allan—Anything that is an emergency contact or has got a risk of suicide we are looking at, so whichever way it presents and whatever way it comes.

Senator MOORE—So these are after people have left the service? So the expectation will be that in your plan there will at least be a seven-day follow-up. So at this stage you are not looking at the kind of program that one community group was funded for, which was for a series of times, so it was for seven days to 28 days into the future.

Prof. Allan—We are not specifying the further follow-up from that. I think we are making the point that if you do not actually find out what is happening at that time you are not going to be able to make further plans. Obviously, we have in place the capacity to have that further follow-up should that be required. The usual thing for us will be that our emergency teams might follow somebody for a period of two to three weeks up to maybe a maximum of six weeks and then we would look at whether or not the particular crisis or issue had settled and what the further care would be for people as to that. That might be general practice, psychologists or case management, depending upon the type of condition.

Senator BILYK—If I could just clarify this, when you talk about people being released from an emergency department or emergency services or however it is called in New South Wales—sorry, but I am not from New South Wales—does that include anybody that is discharged from any sort of—for lack of better terminology—mental institution?

Prof. Allan—Every person who has been an in-patient, including that; yes.

Senator BILYK—Okay, so it is not just an emergency. If you come in as psychotic, say, as opposed to if you come in—

Prof. Allan—We are not specifying suicide or otherwise; we are specifying every person.

Senator BILYK—Okay, thank you.

Prof. Allan—You might have been aware that there is a Queensland program about schizophrenia and seven-day follow-up, but we are actually specifying everybody.

Senator BILYK—Thank you.

Senator MOORE—Professor, yesterday we talked to your counterparts in Queensland. They are trialling a process whereby they are going to fund at the state level as a pilot some people in two locations, people within the emergency department and people within the Division of General Practice whose job it is to coordinate this kind of post institution care and to ensure that people do not fall through the cracks. It was made clear to us that that was a Queensland response to the national program. I am interested to know how that kind of thing is shared. Queensland are doing that. How then do they share that with you, Victoria and all the other places, so that you can see whether there can be a model that can be across the states?

Prof. Allan—There is a number of mechanisms. One would be informally: I would probably have a drink with that person and they will tell me. In a more formal way there is the mental health advisory council. But I actually meet with a group of chief psychiatrists and others from each state in what is called the Safety and Quality Partnerships Subcommittee of the Mental Health Program Council. The issue of suicide and follow-up safety and quality, and those kinds of what-to-do innovations, are part of the things that are on our agenda. This particular issue around suicide and follow-up is something that will be discussed there. So we would have that kind of formal sharing, but I would agree with you that it might be better if there were to be more loud trumpeting of initiatives, because sometimes it does require a personal knowledge or reading journals to find those things out.

Senator MOORE—It is important for best practice but, particularly talking from a Queensland perspective, I know that there is a whole bunch of geography that flows between the Queensland system and the New South Wales system, particularly around the south. You can have treatment on both sides of the border, and unless there is that communication people can be lost.

Prof. Allan—I think there is communication across those border issues. I have worked in both those places so I know that. As for some of the things that we are thinking about, and this is coming back to your original question around follow-up and so on, we can think about a number of things. This comes from the consultation so, please, this is not yet policy or whatever.

Senator MOORE—Sure. Okay, this is from what you have learned.

Prof. Allan—This will all be in the consultation document. There are things looking at the way that young people communicate in a way that is different from what we think about—so can we use texting or other electronic communication to keep in contact with people and to make those follow-up messages? You and I might think that getting a text message from someone is an intrusive thing but for a younger person that might be a very comforting and natural thing to happen, so we could change some of our programs around that. You are aware of the Newcastle postcards project whereby everybody who had attempted suicide was sent a postcard and asked how they were going and were given numbers to follow up and then it was all followed up for seven days, 28 days and so on. That was actually very successful in engaging those people in services. So we are looking at whether there are non-traditional ways of doing that kind of continuity of care and follow-up for people. The other is having a community of practice. This goes to what you mentioned about how the Queenslanders tell us what to do. We are looking at having websites where that sort of information is shared. Obviously, one of the things about New South Wales is that we have eight very strong area health services. Often they can be as separated as the states are in that way just geographically, so the chances of sharing that can sometimes be lost. Obviously, we will be looking at things like showcases around innovation. That is something that we would be sponsoring. We would try to make clinical practice improvement a good thing rather than an unusual thing.

Senator MOORE—I think Senator Adams will probably follow up with questions about the PECC units—and that is the other thing, being a New South Wales initiative. Senator Adams, I think that you would be following up that with questions about triage.

CHAIR—Do you want to do that now, Senator Adams, as we are on that issue?

Senator ADAMS—Yes, Chair. This is coming back to emergency departments. We have heard quite a lot of evidence from individuals and generally from consumer groups about the general triage of someone entering an emergency area first up. There is the fact that if they have a mental illness as soon as they are triaged they are more or less shoved somewhere out of the way and forgotten about—that is the way they feel. Everything has been fine until they have actually mentioned the fact that they have a mental illness and then there is some sort of stigma. Also, as to care, my questions have been about whether there has been anyone with expertise within the emergency department in the triage area so that such people can be triaged straightaway to a different area so that they can be dealt with, rather than their getting more anxious and becoming probably more difficult to deal with as they have been left for hours and hours, as has been described. Can you help me with that? Can you explain what you have done?

Prof. Allan—It goes to what I was saying about the mental health C&Cs in emergency departments. That is very much their job. It is to pick up people in the triage area and make an assessment about what would be the best way for them to be assessed or to make the assessment or, if it is more complex, to think about where that person should be and how they would be looked after in that time for assessment. We see that as a cultural change. Having that person there has made quite a difference and I could tell you some personal stories about that. Yes, that has made quite a difference. We are also looking at an education program about mental health and risk assessment aimed at non-mental health staff. We would be actually targeting emergency department staff to give them the skills to be able to make those sorts of risk assessments and to have some knowledge about how to do things. We think that a lot of the stigma issues come out of people being afraid of what they might find out and being worried about what they are going to do about it if they were to find out. If we can give them some skills about how to deal with that, we think that will make a difference.

We think that the PECC units have made a difference in the sense that we recognise that emergency places are busy and difficult. Obviously for us there are issues about admissions to wards and getting through emergency departments into wards. We think that emergency units where people can have a short stay, initial assessment and treatment and have things fixed up in a 12- to 48-hour period make a difference to the way that people feel they are treated.

The other side of your question is often one of perception and a place to be. There are some difficult issues about emergency departments. If you come in with a mental health problem and they only have a certain number of beds, you are probably unlikely to be lying on a stretcher, because you do not really want a stretcher, so you are not quite the same as everybody else who is lying on a stretcher. That is one thing. And often emergency departments, particularly country ones, have been built without safe assessment places. The place that the person has to wait may not be the most secure, there may be an opportunity to leave and so on. Obviously a number of the tragedies that we have investigated are around not having that safe place. There has been a program of rebuilding that to have a safe assessment room and be able to say to someone, ‘If you have to wait, that will be a safe and comfortable place to wait. We can keep an eye on you and we can make the right sorts of observations.’ I agree—it is a very difficult area and one that we are doing much better in, but obviously emergency departments get busy and there will always be stories that we should not have.

We appreciate that the waiting times are often long. We report on the triage category specified waiting times. We are doing not too badly on that. I will have to take on notice the figures about that, but we are not doing badly. What has been a problem in the past is waiting for a bed for a really long time once an assessment has been made. That has been an issue.

Senator ADAMS—I have been asking questions on discharge. I am from Western Australia and I have had quite a lot to do with the mental health system over there. Just on step down and step up facilities, which was mentioned before, is New South Wales starting to get more of those facilities?

Prof. Allan—We are considering those matters. I do not think that we have step up/step down in the way that you would think about it in some places. We have looked more at the issues of housing for people—looking at that chronic issue—and we have looked more at the issues of community based support, but not necessarily alternative places to be. I do not know whether you want me to say more about that. Regarding step up/step down, when a person is in an acute phase it may be best to think about them being treated by your best services, not by a second-tier service. Sometimes what is more important is—

Senator ADAMS—I am not really thinking about the acute phase but once they are over that—

Prof. Allan—Yes—what happens afterwards.

Senator ADAMS—Often the area where the person has come from has caused the anxiety and the problem and therefore, if they were to go straight back to the same situation, they would probably get worse—

Prof. Allan—Sure. A lot of people have taken advantage of HASI—our Housing, Accommodation and Support Initiative. Over 1,000 places have been opened with that. I think that many of the people that you are talking about would be able to take advantage of that program. We are looking at targeting not just people coming out of hospital but also people who have chronic concerns in the community—also people coming out of prison and there are some special programs for Indigenous people, who have often missed out on that kind of program. That is what we have been looking at.

Senator ADAMS—Are there case managers for these people?

Prof. Allan—We try to put on case managers were case managers are appropriate. That would be the cry of all mental health services: we would like to have more. That is an issue for everybody and it is something that we have identified as an issue. Our own planning figures show that we need to focus on that community support. That is what has been happening lately. Most of the funding—I think it was 82 per cent—that we have put in over the last couple of years has gone to community based efforts, not to in-patient efforts. We will be putting our funds around that. There is no doubt about that.

Senator FURNER—I have a couple of questions around the accuracy of reporting. In your submission you make comment on two areas that I want to concentrate on—firstly, in respect of high blood-alcohol content in 71 per cent of suicides and the link to suicides on country roads. How do you overcome the type of statistic that is based on those being recorded as accidental deaths as opposed to suicides?

Prof. Allan—As you know, the ABS is reviewing those figures. Some of that lies with the way coroners make findings. There will be recommendations, I believe, from national meetings of coroners around the way that they consider those figures. So that is something we can make in submissions to coroners, but we do not directly manage those. I think that the reason for bringing up the 70 per cent figure was really for us to say, ‘Look at the role of alcohol as a factor in suicide,’ and looking at that is going to be part of our strategy.

Senator FURNER—You also comment on cautioning the stats on suicide in Indigenous populations. What is the main concern in that respect?

Prof. Allan—I guess the main concern for us is the way the deaths are recorded—alcohol, accidents and so on. Also it is often an issue of denominator rather than nominator in that you can never be really sure what the population might be. We can get very high rates in little pockets. My experience in Queensland is probably more relevant to this, having worked in North Queensland for a very long time, in that a suicide rate in one community can be artificially very high by a couple of suicides and copycat suicides, and then it might be different the next year. So relying on very small numbers gives a false impression of rates. However, when you look at the overall numbers of course, Aboriginal suicides do remain very high. So using those figures for planning purposes and so on is difficult for us.

Senator MOORE—We had evidence yesterday from your counterpart in Queensland about a quite studied look at the way Queensland data is recorded, and it was put forward to the national group to have a look at. They have seen quite a significant difference and they suggested ways that could be done. It has been quite a focused plan. Has New South Wales done that degree of scrutiny of the data?

Prof. Allan—We have done it to some extent in looking at the rural data. The New South Wales Centre for Rural and Remote Mental Health have looked at that, particularly in relation to farmer suicides and the way that one community can be very healthy and another community can have an enormous problem. We have actually used that data to try to target communities. That has been under a drought package that we funded.

We are looking to move that towards a climate change—if I can still use that word. We are looking to use more of those rural issues around climate productivity, but also to move a focus towards Indigenous people as well. I am sure that you all know that New South Wales has a larger Aboriginal population than Queensland. We obviously have our issues, but we do not have some of the same spectacular ones they do. I have got 20 years of Palm Island and other things under my belt so it is another world—

Senator MOORE—You have got your medal, Professor.

Prof. Allan—But, yes, we need to move to that and we are sponsoring some research around that.

Senator BOYCE—Yesterday we took evidence in Brisbane from the commissioner on the deaths of children and adolescents. What focus, if any, have you put on youth suicide in New South Wales and how are you recording those figures?

Prof. Allan—For young people?

Senator BOYCE—Yes. For instance, we had figures yesterday for 10- to 14-year-olds, and 14- to 17-year-olds.

Prof. Allan—I have got some figures on 15- to 24-year-olds—5.5 per 100,000—but I do not have any figures for—

Senator BOYCE—Are they ABS figures?

Prof. Allan—Yes.

Senator BOYCE—For instance, a member of staff from the commission told us yesterday that their figures suggested that they were at least 50 per cent higher than the ABS figures for that cohort of 10- to 17-year olds—and they are comparative figures.

Prof. Allan—The latest ABS figures are for 2007 and, as you know, there is to be a revision of the ABS data. We have taken the view that we would wait for that revision before we made particular statements about rates.

CHAIR—As I understood it, they started this project sometime before the ABS announced that they were going to revise their figures.

Senator BOYCE—Yes, this was something they had found through the fact that they are carefully analysing each death of a child in Queensland, irrespective of whether there was a revision of how ABS went about it. Could you give me, perhaps the 15 to 24 figures.

Prof. Allan—We said it was 5.5 per 100,000.

Senator BOYCE—Is that telling me that there are no suicides under 15 in New South Wales?

Prof. Allan—I think I am telling you that I will have to take the question about numbers on notice. I do not know that.

Senator BOYCE—Yes, if you could, and give us as much detail as possible. I guess what we are pulling out here is—

Prof. Allan—I was not quite sure of your question. When you said ‘each child death’ did you mean any child death or suspected suicide child death?

Senator BOYCE—Any death that goes through the coroner.

Senator MOORE—They have a special project, Professor, as a result of the concern about young people dying in Queensland, and suicide. They have a special project and I just forget the terms and the years when they were doing the special project.

Senator BOYCE—I think they started in 2002, didn’t they?

Senator MOORE—And I think it went until 2007, I think. They had a public discussion paper. It is a major focus.

Senator BOYCE—Yes. This was a result of children dying whilst in the custody of the department and things like that. That led them to undertake this and set up a special commission for child and adolescent deaths, and to analyse those.

Prof. Allan—Well, good on them! I do not think we have that special project, but it is an interesting one.

Senator BOYCE—The particular part of the commission that came to give evidence dealt with the issue of suicide and they found that it was a greater issue than the statistics would initially have suggested.

Prof. Allan—Obviously, we investigate identified suicides but you were talking about things that are unidentified and you said that they were searching those. That sounds like a very good project. I will talk to my counterpart about that.

Senator BOYCE—If you could give us those figures that would be good. The other areas I wanted to ask about mainly related to issues that have come up today. One of the recommendations that we have had was that it should not just be clinical services that people with mental health problems or people who are at risk of suicide can be referred to, but also community based services. I imagine that Medicare would have hysterics at that thought but could you tell me what, if anything, the department has thought about this particular idea?

Prof. Allan—There are two groups of services. There are services that we already provide for people who have an existing mental illness. So the suicide prevention is part of those kinds of support services. We fund a number of people to do that. I think you are also talking about the idea that there could be some alternative care.

Senator BOYCE—Yes. You could be referred to, perhaps, a naturopath or—

Prof. Allan—Or something; yes.

Senator BOYCE—Someone who is not in NRAS, I guess.

Prof. Allan—I do not think we have thought about naturopaths, per se.

Senator BOYCE—No; that was an example.

Prof. Allan—I understand your point. I guess we have been limited by what Medicare will pay for, in that sense. That is a particular issue. I would hope that the new initiatives announced today might start to address some of those matters. I also think community groups or NGOs would like to provide a different kind of support services and I think that would be something we would be interested in having discussions about. Really, that is part of our strategy around that.

I guess as a youth service model we have a picture of holistic care. For example, we have a pilot program where our child and youth services are tied with Headspace. That is the one at Gosford, and we are looking to roll that model out around the place. That is one area where we see a link with the community and other non-health services. So there is no wrong door: you go in and you get to see the right people no matter which way it is, but you get out of health if you do not need to be in health. That would be the sort of model that we would be looking at. We think that those non-health services are best provided by non-health people. That is what our whole-of-government strategy would be about—encouraging those things to happen.

Senator BOYCE—I suppose it is about formalising that as a pathway. I guess that is part of the issue.

Prof. Allan—I think there is work under our ycentral model to do that, but that will be something that I would hope will come from the consultation around our revised strategy. You are quite right: we are recognising that it is not a health issue; it is another issue. We as health people have got to find ways to help other people take that responsibility.

Senator BOYCE—The Richmond Fellowship today gave evidence that, as far as they are aware, they run the only service in Australia for mothers at risk of suicide through mental health problems—the Charmian Clift Cottages. They also pointed out that, as far as they were aware, there was no data around maternal deaths and suicide in Australia. We decided that we would ask you if you were aware of that.

Prof. Allan—Do you mean women dying in the postpartum period from suicide?

Senator BOYCE—Yes.

Prof. Allan—I am not aware of specifically that. I am aware that there is data around infanticide and suicide linked to that, but I am not aware that anybody has separated the postpartum suicide. Obviously we know about risk.

CHAIR—I would have thought that would have been an issue that would have been looked at.

Prof. Allan—We have looked at the issue of the perinatal period just recently. I know we have looked at the risks of illness in that time. I was not aware that we had any data in New South Wales on suicide per se. We have data around depression and so on, but we do not have incidents of suicide recorded that way. It is an interesting proposition.

Senator BOYCE—Or suicide attempts, of course.

Prof. Allan—Yes. It is recognised as a risk time and I am sure clinicians are aware of it as a risk time, and we have particular programs for at-risk children and young children and unborn babies and so on, and maternal risk goes with that. So we are particularly aware of that as part of our assessments.

Senator ADAMS—What have you got for mums with postnatal depression?

Prof. Allan—We see that as particular community supports, the way that our services run. At the moment we do not have a specified inpatient unit that does all of postnatal depression in the way that some places do. We have been again having a year of consideration of that and looking at particular other places and what plans we might do. So I cannot really say things about that because that is still coming along. You mentioned the Charmian Clift Cottages, and there are other places like Tresillian and so on. There are other places that would take women who are at risk of depression and suicide, so I am not entirely sure it is limited to that.

Senator BOYCE—Women and their young children?

Prof. Allan—And their young children, yes. So I am not sure it is limited to one place. I would have to have a discussion with them about how they defined what the only place was, because it is not clear to me.

Senator BOYCE—And the other question related to the training of police to be comfortable with mental health issues and deal with people in that situation. We are told that your target is to have 10 per cent of the police trained.

Prof. Allan—I think the police would have to answer that question, but I think it is 15. They are looking at a cascading model.

CHAIR—We were told 10.

Prof. Allan—I will take it back if I am wrong; it is too many figures.

Senator BOYCE—I understood the Department of Health was providing that training to the police force.

Prof. Allan—We provide people to help with the training and we work with them in developing the training. The training is under the auspices of the police department, so that is part of their compulsory training. Their model, as I understand it, is that they are looking to train senior officers and those people who would be in charge of shifts first, and looking for a filtered-out effect on their younger staff. I am sure you are aware that the very good characteristic of police is that police follow their officers and do what they are told, and they see that as a very good way of getting that training in. For New South Wales police it is four-day training, I believe, with some refresher programs—a very intense training program. I have seen parts of it and I have seen presentations by the police. It is very comprehensive and very good training. In terms of whether the training numbers would change, that is something you would have to ask them about. That is something that we will be looking at in our whole-of-government strategy again, obviously.

Senator BOYCE—I was going to make that point—it puts a whole-of-government hat on.

Prof. Allan—We think it is a great program, they have got very good results in their trial areas. They are now looking at rolling it out across the state. We will be addressing that and the role of that in our further discussion document strategy.

Senator BOYCE—Thank you.

Senator BILYK—I want to take a bit of a different tack. I am interested in whether you have any information on what the New South Wales government does to support families after a suicide within the family.

Prof. Allan—For bereaved families?

Senator BILYK—Yes.

Prof. Allan—There are a number of things about that. We have particular policies about open disclosure, about giving families all the information that we can about what has happened and why it has happened, and offering support to people. So we would be expecting that, if our service had been involved, we would still follow on—

Senator BILYK—How does that happen? Do you approach people?

Prof. Allan—We approach people. That is part of the reporting—that they have done that and what the outcomes of that are. So that is part of it. When we have done the root cause analysis investigation, there is an open disclosure session about what we have found and what the outcomes would be. There may be particular causes or systemic changes that are needed. We would expect that open disclosure session to happen with families around that. We also fund some work around grief counselling services—independent services for that. It might also be, of course, as you would understand, that often people do not feel that they want to have counselling from the same people who have given the care. So we advise people about other services and we fund some of those services.

Senator BILYK—There are statistics out there that show that, if you have had a suicide within the family, that increases the chances of potentially another suicide within the family. I am just wondering what processes take place. I realise that it is a hard area to deal with because some people do not want anything to do with anybody after it—I know that—and some people are looking for support. It is pretty hard to please all the people all the time. Do you give them brochures? Do you send someone out to see people? Do you ring them up? I need to get a bit more of a handle on how you actually do it.

Prof. Allan—I think the usual clinical practice is that after you have made the initial contact you give them what they need.

Senator BILYK—So someone from the mental health area would do that?

Prof. Allan—If there was a postvention issue—if it happened—firstly, postvention, we have to see the people; we have to make contact with them. Some people just say, ‘I don’t want you; off you go,’ and sometimes we are able to say, ‘Let’s talk about it at a later date.’ The open disclosure session is another at time at which it is a bit less raw and you can make that link with people and discuss with them what they want. We are really governed by what people want. It is one of those things you know what is good for them but you cannot make them do more than what they are going to do.

Senator BILYK—Sure. Bearing in mind that not all suicides relate from a mental illness and not everyone who suicides has actually been hospitalised previously for anything, do you try to contact everyone or families who have reported suicides?

Prof. Allan—We do not go looking for people that we do not know to talk to them about their suicide. There are probably not mechanisms for doing that—not for identifying people in that way. We would expect that many people who had been bereaved by suicide would make contact with our service or other services. That is probably the way into it. We do not seek them out.

Senator BILYK—You might know the answer to this question, but would a family GP generally recommend this? Say there is a suicide outside the known circles—for lack of a better word—would a family GP have information to refer people if they wanted to go to talk about things or get information?

Prof. Allan—I would think that family GPs would have a number of layers of things that they might do for people. They might decide to take that in house and, depending on the relationship with that person, they might be the best counsellor. They might use grief counselling services, like Lifeline or other grief counselling services, in the way they would for anybody. If they thought that person had a mental illness, they might refer to us or to other psychiatry services. I think it depends a bit on what they might see. I think that in general your question is a very good one in the sense that you are saying that we do not always know what is best to do in these situations.

Senator BILYK—That is right. What suits me might not suit you, for example.

Prof. Allan—We would hope that things like our community of practice and those sorts of discussion about what is best practice would lead to some better information about that. Your question does raise for me the fact that we probably have not done that kind of postvention service in Australia very well. That might be a cultural thing. We are all expected to grin and bear it and just get over it. We do not always examine all the issues that have happened for people; that is certainly true.

Senator BILYK—I think it is an area that needs to be looked at. Statistics show that if you have had someone in your family commit suicide, or even having attempt suicide, it does increase the risk for other people within the family.

Prof. Allan—That is a very important point. You do not know whether it is a suicide or whether they have a shared condition that might be common to them. I can think about my clinical experience of such matters. It is a very complex set of issues, isn’t it?

Senator BILYK—Undoubtedly.

Prof. Allan—The issue of awareness of help afterwards is something that might be very useful in a public awareness campaign.

Senator BILYK—Yes, support for families afterwards.

Prof. Allan—I think the whole issue of support for families of people with mental illness or who suicide really needs further examination. I overheard the previous witness talking about privacy and giving information. I do not think it is like that. I think that people do understand that they can listen and so on. But that is something our plan is going to look at again. That has been identified for us in our consultations as a very important thing, so we will look at that over the coming time.

Senator BILYK—Great. Thank you.

CHAIR—I want to follow up on that particular issue of contact. After a suicide, is no family member contacted if that person is in hospital? For example, if someone who attempted suicide is taken to hospital and they pass away in hospital, is there no contact with the family?

Prof. Allan—There is contact.

CHAIR—Is there follow-up to offer counselling services or provide information on access to such services?

Prof. Allan—You are asking me if there is a contact and then do they follow-up again; is that right?

CHAIR—What is the contact about? Let us put it that way.

Prof. Allan—One is about letting people know what has happened and the other is to offer assistance and counselling, as appropriate, and to offer further information and further counselling as appropriate.

CHAIR—So there is that level of contact with each family?

Prof. Allan—Yes. Whenever there is a suicide that has been associated with our services, that would be a reportable incident to us. Part of that reportable incident brief contains not only the information about what has happened but also what has happened afterwards and what information has been given to families, and that the contact has been made and that information has been offered. That is part of the process that we expect people to report on, and we look at that further in the investigation.

CHAIR—But subsequent to that is there no follow-up to deal with the issues around what they call ‘contagion’? I do not like that term.

Prof. Allan—The follow-up would be that we then formally discuss the outcome of our investigation with the family, and so that is another opportunity. We do not separate those two, in that sense. But we might also, from the initial contact, be having further follow-up with people. I am not sure I explained that well.

Senator BILYK—Part of my question was also about those people who are outside, having a known psychiatric illness or not being in a hospital—for example, the young lad who goes and hangs himself because his relationship has broken up, having had no previous issues that would lead people to even suspect he might do that. I am worried about those families as well and how they deal with it.

Prof. Allan—We know that nearly two-thirds of the suicides in New South Wales are people who do not have contact with mental health services. We can speculate that many of those people should have been aware that there was probably a mental illness involved, and contact should have happened. Your question is around how those people have somebody ask how they are. Often that depends upon family networks. One of the things that we think are really important is the notion of mental health first aid, which is the idea of giving a large number of people in the population the tools to go and ask someone if they are all right and to know what to do if they are not. Often people shy away from asking that question of friends and relatives because they think: ‘What am I going to do if I discover that this is the case?’ So I think it is about empowering the community to be able to care for each other, and those are simple programs that we are rolling out and looking for penetration for, particularly in at-risk communities. At least there are likely to be people around you who have the desire and the capacity to ask you how you are and then to link you into the right kind of service. I think that is what you are asking me about.

Senator BILYK—Yes.

Prof. Allan—If you are not linked to a service formally, you have to get there somehow. You might do it yourself, you might have somebody who cares about you do it or you might have a stranger just notice that about you. That is the way our society works.

Senator BILYK—Yes, I see it as linked to that issue of the stigma that is still associated with suicide. Very often people will not talk to other people. They, as the sister, aunt or whatever, do not want to get into talking about X committing suicide and about how they are feeling. As I see it—and this is more of a statement than a question—it is still linked to the fact that we are not relaxed about talking about death in general as a society. It is still quite taboo in a whole lot of ways.

Prof. Allan—That is why I think that things like mental health first aid aimed at lay people help them to have the skills to deal with it when they notice it in others. It also helps to destigmatise it for them. When they know about it, it is a terrible thing, but it is not a terrible thing to talk about it.

Senator BILYK—Yes.

Prof. Allan—Examples of things that help are workplace initiatives to just think about it or targeting community groups to have that skill.

Senator BILYK—Thank you.

CHAIR—With the HASI program, how long can people stay in the accommodation that you provide?

Prof. Allan—There are different packages tailored to different people. With some people it is forever. With some people it is short term as needed in terms of crisis accommodation. There are also different levels of support, so we are looking at a range of people who might need short-term short support because of the particular issues that you were asking me about before versus people for whom this will be an alternative to institutionalisation. I admit that even I have trouble understanding HASI. There are five different releases of HASI. Some have got (a) and (b) in them and there are different levels. They are about the times we have had money and help us track that money. They are also about addressing a particular need. For example, in the last one our statistics had shown that Indigenous people had been underrepresented so we have targeted money at that. The next one will be targeted at prisoners. It is a range according to people’s needs.

CHAIR—Today we had evidence from a woman who was talking about the loss of her daughter, and there were a whole lot of specific questions to do with New South Wales. I do not think that we can look at all of them this afternoon, but in terms of the integrity of this committee, as they were raised with us, could we have someone look at that evidence?

Prof. Allan—Sure.

CHAIR—In particular, it went to the closure of services at hospitals that were providing employment for people with schizophrenia: Cornucopia and MARS.

Prof. Allan—There has not actually been a closure of Cornucopia.

CHAIR—It was a threat of closure.

Prof. Allan—There is no threat to close it.

CHAIR—There is no threat to close it? Okay.

Prof. Allan—I do not know how long you want to go into that—

CHAIR—We cannot. We are running out of time. That is why I am putting it on notice.

Prof. Allan—I guess the issue is revision of that service and moving some of it to an NGO from the government. There were concerns around that. The minister did something but that was stopped. We are now consulting with people who are doing an external review of that service. This is really about our commitment to look at realistic employment issues for people in the community.

CHAIR—Good.

Prof. Allan—There are many takes on that particular issue but—

CHAIR—There were also closures of mental health centres, one of which was Chatswood. I did not get the other one.

Prof. Allan—There are closures in some community buildings which were run down and condemned. The proposal was that those services would be relocated to be next to the hospital that was part of that service. So there has been an issue around whether they are better provided from a base in the community or from a base at the back of a hospital with a different doorway and entrance. Many people have opinions about which is better and which is not. The reality was that we were forced to close the building because the building was an issue. The issue is whether cost savings from relocation of one campus with a separate entrance are better than those of a different campus.

Senator MOORE—The services have been maintained, just in different locations.

Prof. Allan—As I understand it, the services are the same.

Senator MOORE—My other question is more whole of government. I am interested in the way someone who has a mental illness is treated by other departments such as transport, in the idea of unpaid fines and the impact they may have on someone and in who is the interceptor, if there is someone who has a mental illness and is caught up in situations with which they are not able to cope and then the system just churns through the process. I would encourage you to have a look at the submission.

Prof. Allan—We would be very happy, if you want to supply that to us, to have a look. Fiona informs me that the Attorney-General has actually made an announcement around a pilot program to target that particular area. So we will look at that for you.

Senator MOORE—Even though it is in one submission, it is important for us to have that finalised in our minds.

Prof. Allan—It arose with a patient I saw this morning. I understand exactly the issue.

Senator MOORE—Thank you very much.

CHAIR—Although it was evidence from one person, the issues are the same through a number of the written submissions that we have. We also received some further evidence from other witnesses. So I would appreciate it if you could look at that and address those issues as well.

Prof. Allan—So you will be supplying something to us about that.

CHAIR—Yes, we can supply you with the *Hansard*s et cetera.

Prof. Allan—Thank you very much. We will certainly look at that for you.

CHAIR—Thank you. That concludes our evidence today.

Committee adjourned at 5.01 pm