COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Suicide in Australia

THURSDAY, 4 MARCH 2010

MELBOURNE

BY AUTHORITY OF THE SENATE

SENATE COMMUNITY AFFAIRS
REFERENCES COMMITTEE
Thursday, 4 March 2010

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

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

Senators in attendance: Senators Adams, Bilyk, Boyce, 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 9.02 am

HARDY, Mr Edward John, Chief Executive Officer, Australian Suicide Prevention Foundation

HORGAN, Clinical Associate Professor David, Chairman; Medical Director, Australian Suicide Prevention Foundation

CHAIR (Senator Siewert)—The Senate Community Affairs References Committee inquiry into suicide in Australia will hereby recommence. I welcome the first witnesses. I understand you have both been given information on parliamentary privilege and the protection of witnesses and evidence.

Prof. Horgan—That is correct.

CHAIR—We have received both your initial submission and the new document. I invite you to make an opening statement and then we will ask you some questions

Prof. Horgan—Thank you for inviting us to appear. Suicide is obviously a very important issue as far as Australia is concerned. I will talk to the document we have given you this morning and make a few extra points. Forgive me for simplifying it, but I spend a lot of my life lecturing about suicide prevention and depression. Regarding the core clinical issues, there are actually four things that kill people. Number one is emotional pain and despair—it may happen subtly; it may happen gradually. Number two is hopelessness—all the research into depression and suicide says that what kills people is hopelessness. Number three is depression. Number four is the inability to sleep.

Moving to the next page, the fundamental reason we set up the foundation, the website and the telephone service—and we have been doing this since 1997, so we did not just start this yesterday—is that, really, there are vast numbers of people with an embarrassing or stigmatised illness. Even if I had this illness myself, I would not find it all that easy to go to a doctor and say, ‘There is something wrong with me.’ So we have decided that what matters is providing intervention which is anonymous, without embarrassment, always available 24 hours a day and never engaged, as some of the telephone services may be.

As I say, we have been at this for 15 years. I personally apply to the foundation and to the services that we provide some of the technical knowledge that I have myself. For better or worse, I am known to the psychiatrists of Melbourne as somebody who treats the most impossibly severe depression, people who are highly suicidal. I do this all on an outpatient basis. I very rarely admit people to hospital and, luckily, I very rarely have a suicide. So there are things that can be done to save people’s lives.

With regard to the next page, where we talk about the real figures, obviously you will have heard lots of concepts about the figures about suicidal thoughts, suicide attempts—and, when we say ‘10 additional attempts’, they are probably determined attempts. There is a spectrum of suicidal ideation from where it is a fleeting possibility to where it is a persuasive option, so that is one way of assessing suicide. The other issue is that, when people make attempts on their lives, the reason it is so ambivalent is that the sick bit wants to die and the healthy bit wants to live, so obviously we try to intervene on the appropriate side.

Suicide is, of course, very distressing to a whole range of people—to family members and to those associated with it—and yet, in terms of funding, obviously it is a concern that there is less money given to suicide than, say, to other conditions which are as prevalent or even less prevalent. There is actually more of a problem with suicide in the sense that, if a death occurs through suicide, there are traumatised people left for many years afterwards wondering why, how and, 'Should I have done it?' and feeling guilty. It is not quite the same as if somebody dies in a car accident, so it does have more repercussions on a lot of people.

On the next page is, 'Why do people attempt suicide?' The fundamental issue is that it is emotional pain and despair. What are called 'psychiatric autopsies' say that between 60 and 90 per cent of people who have died from suicide have had depression at the time, depending on how you define depressive illness and how you then define what we call subsyndromal or less severe depression. That is one issue.

The other issue is that people seek intervention 24 hours a day. We have been running this web service for 10 years, basically, and our statistics show that it is seven days a week, 24 hours a day. It is 3 am just as much as it is 11 am. People want help all the time, and that is obviously impossible to provide manually.

The core issue is the huge numbers. The National Survey of Mental Health and Wellbeing says that in 12 years almost half a million Australians have thoughts about suicide to a greater or lesser extent. As I say, the numbers really cannot be dealt with by counsellors, psychologists, psychiatrists, doctors or whatever. One of the things that we do on our website specifically is that, apart from being available all the time, we want to deter action. We want to buy time because, if we can buy time and persuade people that there is something that can be done to overcome the sense of hopelessness that they have, then interventions that are more appropriate can take place—or, if we had more resources, we would have more persuasive interventions on the internet. One of the things that make our website different is that we give people specific bits of advice. We actually make specific statements to them. A number of websites say: 'Go and call a friend. Call a doctor. See a doctor.' The harsh reality is that many people then do not know what to say or do when someone says, 'I'm feeling suicidal.'

The next page is about Australians not receiving best practice management of depression. This is not something that we included in our original submission but the more I thought about it, the more I thought that this was an appropriate forum in which to discuss something like this. I might remind the committee—if I may, when I am going to say something controversial—that, when I am talking about this and telling people things that are out of keeping with standard Australian practice, please do remember that the old tradition of shooting the messenger is now considered to be in very bad taste, especially by the messenger!

I specialise in treating depression. One of the bizarre things that I cannot understand and many of my colleagues who do the same thing cannot understand is: if human physiology is the same all over the world and the availability of medications is fundamentally the same in Australia, Britain and the United States, why is it that giving people two antidepressants simultaneously is standard practice in Britain, in the United States, in Canada, in Germany, in multiple countries in

Europe and in Ireland and why is it that here it is considered almost a crime? There has been a huge traditional resistance to the use of two antidepressants simultaneously. I have put some anecdotes there which we can discuss in question time. The one that distresses me most is X.

The next issue is dealing effectively with the huge numbers of people involved. Apart from the huge numbers, people do not want to go and see doctors and counsellors. Young people do not want to do it. Males do not want to do it. But the reality is that, while the research says the vast majority of people who commit suicide have never had treatment, it also says that the vast majority have talked about death or suicide to somebody. And, if they have talked about it, presumably they have looked it up on the net. Everybody looks up everything on the internet these days. If they have not looked it up, their friends do. They have talked about death or suicide: ‘Well, I’ve looked it up on the internet.’ So it is very important that, when people do look it up, they come across something that goes straight to the point. Because we have been at this for a long time and because I do a fair number of things on the internet, I know, as you all do, that people have a very short attention span, especially if they are distressed. So that is why our website goes straight to the point, so that people get immediate advice as soon as they click on.

That fits in with what is on the next page about engaging males in help seeking. As you presumably know, 75 or 80 per cent of the deaths are in males because they use more lethal means. Also, if people survive a suicide attempt, five per cent of the males will eventually die in a subsequent suicide attempt. Women survive suicide attempts more often, so 80 per cent of the survivors are female, but, even so, two per cent of them will go on to die in subsequent suicide attempts.

We then put in some recommendations, which are perhaps an expansion of what we put in our original submission. I would mention No. 1, which is about the effect of stigma. We may all have great ideas that we wish there was not a stigma associated with depression, with psychiatric illness, but unfortunately there is. We do not want to replicate the situation that occurred in Britain, say 30 years ago, where they did a huge campaign trying to eradicate the stigma against depression. They did a population survey beforehand; they did a population survey afterwards, and nothing had changed. It is very difficult to eradicate stigma, so I think what we have to do is just accept that we have to operate around the issue of stigma and accept that therefore people want intervention which does not stigmatise them any further.

No. 3, we want an economical means of intervention. I am sure you will have lots of people saying, ‘Train more counsellors, train more psychologists and train more this, that and the other,’ but it is not financially feasible. What you really want is something that can be applied to 10,000, to 100,000 or to 500,000 people at no extra cost. We know how to do this if we have the resources.

No. 9 is the use of medication strategies. I have already talked about that sort of issue, but the other inescapable statistical fact is that suicide rates in any country in the world are affected directly by how much or how little GPs prescribe antidepressants, so recognition and treatment of depression are important. I would also say that treating depression when it is mild with, say, cognitive therapy alone is fine, but, once people’s lives are in danger, treating people without also giving them antidepressants is very difficult to defend. It is very important that doctors understand that no harm can be done, really, by giving people antidepressants, and huge numbers of lives can be saved. I can talk more about that statistical correlation if you are interested.

Our conclusion is that really people want definitive intervention at any hour of the day or night, and that is what we provide. We can service the huge numbers of people and we would like to do a lot more if we could. Thank you.

CHAIR—Mr Hardy, do you want to add anything before we start asking some questions?

Mr Hardy—No. We have pretty well covered everything. Certainly the focus is on the numbers: how to address the numbers and how to handle the numbers. We must use technology as much as we use professional skills. We do need more professional skills, but we will never have anywhere near enough, just because of the volumes involved.

Senator MOORE—Could I just clarify whether your foundation gets any government funding at the moment.

Prof. Horgan—No, we do not.

Senator MOORE—Is that because you have not applied or because your applications have not been successful?

Prof. Horgan—Basically, we have not applied.

Senator MOORE—You are not going to get anything if you do not apply. Is there a philosophical reason for that?

Prof. Horgan—Firstly, I was an individual. I set this up as an individual many years ago. I applied at that stage and was basically told that there was no way money would be given to an individual running a suicide prevention service. I set this up in conjunction with a businessman, Mayer Page, who unfortunately died, and we were told there was no way. At one stage I wrote a letter to the minister, asking about general support and was told that I had misunderstood the issue on which she was talking and that there was not any particular money available for whatever concept I had written to her about at the time.

Senator MOORE—Was that state or federal?

Prof. Horgan—That was federal.

CHAIR—Who was the letter to and when?

Prof. Horgan—That would have been to Minister Roxon two or three years ago.

Senator MOORE—You would be aware of the national suicide prevention plan—

Prof. Horgan—Yes.

Senator MOORE—and the various funded parts of that. One of the core elements is Wesley looking at developing networks across the country, in terms of what is available and how people can coordinate their services. Has Wesley been in contact with your organisation to see where you are operating and what kinds of services you provide?

Prof. Horgan—No. We find it intriguing that we are the only entry under suicide in all—

Senator MOORE—I noticed that. I am very bad with computers, so I do not carry mine around, but it came as a shock to me that in the phone book, if you are rational enough to look in the phone book when you want help, under suicide you are the only one listed in all directories.

Prof. Horgan—Exactly, and yet nobody ever contacts us, and I have seen various directories of suicide prevention services and nobody ever mentions us.

Senator MOORE—Do you know why?

Prof. Horgan—The cynical bit of me thinks it is to do with political pressures and so on—that everybody is competing for fame and so on. We really see ourselves as providing a service, not looking for a profile.

Mr Hardy—It is a complementary service to whatever is available from other groups.

Senator MOORE—In your submission you made it clear that you do refer people on, so that lack of engagement is certainly not on your side. I note that you have a significant email base and a website, as well as your phone. So on that basis you actually do know what is around and try and help people that way.

Prof. Horgan—Yes. Even the front page of our website gives people some of the immediate contact numbers to ring and so on, because we all agree that, if people are very distressed, that person-to-person contact is better. What we are trying to do is intervene early or when the person-to-person contact is not available because they are engaged or whatever.

Senator MOORE—In terms of that kind of formal process—and I gather that there have been a number of programs listed in different ways, with funding and the focus on trying to coordinate—are you involved in any other networks apart from the one that Wesley is doing under LifeForce, particularly in Victoria, which is your base—is that right?

Prof. Horgan—Our base is Australia wide. We happen to be working in Victoria, but we see ourselves as offering services all over Australia and especially to isolated people where there are no services available. Those who have access to the internet can hopefully get a whole range of information. For example, we also run an aftersuicide.com.au website. We keep making offers to various organisations—that they can have information put on our website so that people can contact them, but people do not take up those offers. We had a display. There was a post-suicide conference run by the Salvation Army here in Melbourne about nine months ago and I believe John went around to quite a number of people.

Mr Hardy—We have had involvement with a number of smaller groups. We obviously have some involvement with the Salvation Army. We will be participating in the Griffith University information gathering for Queensland; but, in return, we want to make the same information available in a more general sense.

Senator MOORE—You have been engaged in the Griffith process.

Mr Hardy—As of three days ago, yes, when they contacted us.

Senator MOORE—So you have a longstanding arrangement with Griffith! But, in terms of process, at least that network has begun.

Mr Hardy—They have started to do something.

Senator MOORE—Their basis for engagement is to establish an effective research base across Australia. Their funded idea here is to get that effective research, and so they have engaged with you. How did Griffith University make that contact?

Mr Hardy—By email, asking us why we had not responded. When it was pointed out to them that this was the first request that we had ever received, they then apologised by email. And one presumes, therefore, somebody has nudged them.

Senator MOORE—Whatever has happened, at least you are now engaged. That is good.

Mr Hardy—Yes, with that group. That is right.

Senator ADAMS—I would like to ask you about the use of antidepressants. You commented that someone can be on an antidepressant and then, for some reason, they can decide or the person looking after them can decide to change it. Could you explain that scenario?

Prof. Horgan—The problem with antidepressants is that we discovered them by accident. We do not really know how they work, and we do not know which antidepressant will work for any individual person. We give a patient an antidepressant and, statistically, that antidepressant has about a 50 per cent chance of being effective and totally eradicating their depression.

In terms of this discussion, we are obviously particularly concerned about people who, because of their depression, are in such terrible emotional pain and in such a state of hopelessness that they think they want to die. If we consider depression with a severity scale of, say, zero to 10, a lot of people might say that their depression is eight or nine out of 10 in severity. We give them an antidepressant, it locks onto their biochemistry and, within two or three weeks, their pain or their depression has gone down to about, say, four out of 10 or five out of 10. However, no matter what we do with the dose of the antidepressant, we cannot get it any better than that.

Traditional practice in Australia is to take the patient off that antidepressant, which, unfortunately, means the illness is going to come back again, and to start them on the next one in the hope that the next one will lock on. But, if any antidepressant has only got a fifty-fifty chance of working, it may not lock on. What happens is that people who are despairing get very distressed. As the illness comes back again, their incapacity comes back again. The family lose sympathy because it is a matter of ‘Here we go again,’ and people feel more isolated. So it is actually quite a dangerous situation when people then feel that there is nothing that can be done. As patients of mine have said when they have had it done to them by other psychiatrists: ‘Wash-outs are hell.’

For about 25 years in the United States and Canada and for about 20 years in Britain, the practice of doctors has been that, when somebody is taking an antidepressant and it has reduced the severity of their depression down to about four or five out of 10, rather than blow away the benefits that that person has got from that antidepressant, they simply add in a second antidepressant. That makes a lot of sense. That is what doctors do when people have asthma and that is what doctors do when people have high blood pressure. Research says that it is effective in about two-thirds of people in whom you do that. If you ask other psychiatrists who do not do this, they say, ‘Oh, there’s no proof,’ or ‘It might be dangerous’ or whatever. Leaving that academic battle aside, I think the fundamental reality is that psychiatrists all over the world do this, except in Australia. I believe, therefore, that many people suffer unnecessarily.

The practice of adding a second antidepressant is so safe, if you like, that a couple of years ago there was a huge trial done by the department of health in the United States called the STAR*D project, which was about treating resistant depression. In that trial, with absolutely no safety concerns or precautions, combined antidepressants were one arm of the trial. It is a routine technical procedure that doctors do, and it is considered so routine that GPs in the United States and Canada do this all the time.

I was just reading an article recently in a magazine called *Advances in Psychiatric Treatment*, which is the ongoing professional development magazine for psychiatrists in Britain. The article said that the use of combination antidepressants is widespread in clinical practice. So it is widespread. Human physiology is the same the world around, but there has been a tradition in Australia not to do this—so much so that pharmacists get alarmed if they see a prescription for two antidepressants simultaneously, and GPs have been warned by some previous academics: ‘Don’t you dare do this, or I’ll stand up in front of the medical board and say you shouldn’t do it.’ It is slowly changing. I am seen as one of the people who is trying to push this change in Australia. I believe a lot of people suffer unnecessarily, whether it be from residual depression or from suicidal ideas, because they do not do this. Can I read you out a brief email that I got about two weeks ago. This is a man who is an elite athlete and a professional. He writes:

> Hello David,
>
> My name is—

whatever—

> and I have been suffering from depression for eight years now. I am now 30. The illness is severe and treatment has only been partially effective. I am sorry to contact you like this but I feel like I am nearing the end of the road as far as treatment options are concerned and I am trying last resorts, as I have lost hope in recovery and cannot really see myself continuing on like this for much longer. I really want to believe that I can get better but surely after eight years this should have happened. You probably get emails like this all the time, so I do not really expect a reply but, if you are able to offer any assistance, it would be appreciated more than you could possibly imagine.

I have replied, of course. He sent me a few more emails. He has never had combination antidepressant treatment. He is basically saying that he is going to kill himself without combination antidepressant treatment.

Senator ADAMS—Would people remain on combination antidepressants forever? I am trying to get to the bottom of the use of these drugs and their influence. Valium is one drug that I am thinking about. Someone I knew who had been on that drug for a number of years had a completely different mind. They had become a different person.

Prof. Horgan—I think there is a lot of misunderstanding about antidepressants versus other psychiatric medications. Things like Valium, Xanax or sleeping tablets in general can be addictive. So people can keep on taking them for long periods of time. They are useful in the short term. They are very useful short-term emotional pain-killers, but more than short-term you have to take into account the possibility of addiction. They are radically different from antidepressants.

Anything that is going to be addictive does something nice for you straightaway and when it wears off you feel bad again, whether that be Valium, heroin or alcohol. Antidepressants are totally different. They lock onto damaged chemistry and it takes them one, two or perhaps four weeks to do that. When you stop taking them, you do not notice anything for a few days really. So, therefore, your brain does not get addicted to antidepressants. In fact, if you distinguish between tranquilisers, which can be addictive, and antidepressants, there are never reports of people getting addicted to antidepressants.

There is a problem when people stop taking antidepressants, but that is not considered addiction; that is a technical issue. What actually happens is that depression is like cancer. In fact, it is described as malignant sadness. It is like cancer. It digs in, it gets more and more resistant to treatment the longer it has been going on and it tries to kill some people, and it comes back again. Effective treatment is like chemotherapy. If somebody has mild depression then treatment by a psychologist or a GP offering them cognitive therapy will be fine and they may not need medication.

There is good research that shows that cognitive therapy is effective for mild to moderate depression—but, once you get to moderate and severe depression, treating that sort of illness by therapy alone is depriving people of the second arm of treatment, basically, which is medication. The two treatments are complementary.

If you do not eradicate depression it is like not eradicating cancer—it stays around in people’s biochemistry and comes back to get them. Only 50 per cent of first-episode depression is going to be eradicated, 15 per cent is going to remain fairly permanent and 35 per cent will recur. What effective treatment with antidepressants will do—by giving people enough of an antidepressant, being willing to change the antidepressant or being willing to combine the antidepressant; there are a number of stages in the proper use of medication—is eradicate the illness. I will give you an example of the issue I am talking about there. Dr Y and Mr Z both had combination antidepressants. Dr Y, having been off work as a doctor for 15 years, has seen a dozen psychiatrists, and has gone back to work as a doctor, taking large numbers of antidepressants. She is now down to four tablets a day, because what happens is that, if you eradicate depression, after a while you do not need this medication and you can withdraw it. You may always have to stay on a low-dose preventative medication—almost like low-dose preventative chemotherapy—and at times you may have to vary the dose slightly, but if you use enough intensive treatment you eradicate the illness, and then people cannot absorb this amount of medication. It is the same with Mr Z, who was basically told that nothing more could be done for him. At one stage he was taking high-dose combined antidepressants and now he is taking low-dose medication—and earns literally millions of dollars a year. So it is really a question of titrating the approaches to the illness. If you effectively treat the illness long enough then it will die away. If people could understand that then their chances of suicide would be much less. That is what we try to emphasise in our service—that we can in fact eradicate depression; we can eradicate suicidal thoughts.

Senator FURNER—Professor, could I ask you to elaborate on your fourth recommendation? We heard from a witness in Brisbane about their post-internet proposals and techniques in dealing with their clientele. I am wondering whether you can elaborate on what the initiative behind that is.

Prof. Horgan—The core issue that we are emphasising is that there are huge numbers of people where there is no way they are going to ring counsellors. Neither the government nor anybody else can afford to provide counsellors and psychologists to deal with half a million Australians per year who have thoughts of suicide—or, indeed, their friends who are also worried about someone and therefore want some advice. So we believe that the only way of dealing with the huge numbers involved is through the internet. But when you go onto internet sites and look up suicide or suicide prevention you see the same thing: suicide is caused by emotional pain and despair. Yes, we know that—but it does not actually say what to do about it. So what we emphasise is: if you have some medication that is safe to use, take some medication and go to sleep; if you are in emotional pain, take some medication that will stop the pain. That way people who are in pain will not lash out and do something. As you would be aware, while there are a number of people who die from depression, typically something emotionally painful has happened as the last straw. If we can give people some way of stopping the emotional pain, or give them advice about it, then that would actually stop people feeling they had to escape the terrible pain by doing something drastic.

The other group of people who kill themselves are the ones who have been thinking about it for a while, typically males gradually getting more and more depressed but perhaps not willing to go and see anybody. So they can go onto a website. Our website goes straight to the point. I dreamed up the concept, because I ask this all the time: what would persuade someone not to commit suicide? So one of the core messages on every page of our website is: you would never advise a friend to suicide. I see a woman who tells me she has suicidal ideas—nine out of 10 in severity, it is because of chaos in the relationship with her partner—and I ask: ‘Would you advise a friend of yours with a chaotic relationship to kill herself?’ She will say, ‘Of course not’, so I will ask, ‘So why would you tell yourself something else when you would tell your friend not to kill themselves?’ It is that sort of persuasive message, if you like, that psychiatrists dream up from years of experience, that we put on the internet.

We also put on things like ‘Bad times will pass; just hold on,’ because what the depression or the despair tells people is that things are terrible now and always will be terrible. Having an outside message saying that bad times will pass says things like: ‘Other people have felt as terrible as you have and are now feeling glad still to be alive.’ So it is any of the things that we think would persuade people.

If we had the resources, we would like to build something much more persuasive, whereby people could log on to some sort of theme or phrase on the net that rang bells with them on our website and we would then provide almost a flow chart along the same lines as what psychiatrists say to people all the time. There are two things that keep people alive. No. 1 is persuasion that they will get better and that there are things to do—so it is trying to persuade people’s line of thinking. As I say, psychiatrists do this all the time. No. 2 is appropriate treatment of depression. The two things have to happen simultaneously.

Senator BOYCE—I want to go back to your idea of the combination antidepressants. I am assuming that no-one would start with two antidepressants—you would start with one and see what happens. Is that how it works?

Prof. Horgan—On 29 December, in the international psychiatric literature, Professor Blier, from Canada, produced a very impressive paper showing how he started treating people with two antidepressants simultaneously and compared them, on a double-blind basis, with people taking one. He found that the people taking two did significantly better. But that is investigation. It is by no means something we would advocate.

Senator BOYCE—Overseas it would still be normal to start on a single antidepressant?

Prof. Horgan—Most definitely.

Senator BOYCE—You mentioned best practice. Is that what is considered best practice in the countries you have mentioned?

Prof. Horgan—It is considered an option that psychiatrists are expected to be able to use. Professor Stephen Stahl is one of the, if not the, world’s best-known psychopharmacologists. He is based in the United States. He visited Australia and met our specialised interest group about 12 years ago. When we talked him to him about this issue, he said, ‘I like Australians but I find it embarrassing that the issue of combination antidepressants is still considered controversial in Australia.’

Senator BOYCE—Do you put this down to some sort of philosophical attitude or does the way we go about funding our medications have some effect? Have you got any thoughts on why it has not happened here?

Prof. Horgan—There cannot be any scientific basis to it not happening, because it is routine practice by hundreds of thousands of psychiatrists in the world’s most advanced economies. So it is not going to be a scientific issue. I suspect what it is going to be is that, when we only had limited numbers of antidepressants, some of the combinations were dangerous. When people did not understand, some of the combinations were dangerous. So there would have been one or two cases of death or of people being very ill. That led to some of the academics issuing a blanket prohibition and then, once they had painted themselves into a corner, not being able to say, ‘I think perhaps I overstated the case.’

Senator BOYCE—We have had evidence in other hearings that around this that suggests that help-seeking of itself can be useful, that suicides are lessened once people seek help and that, rather than the use of medication, the help-seeking as an act can be helpful. How does that gel with what you are telling us? You also mentioned in passing that there was a correlation between the use of antidepressants and a reduction in suicide rates. Could you tell us a bit more about that, please?

Prof. Horgan—I do not know if you have had the opportunity—if you have not, I hope you do—to hear Professor Robert Goldney in South Australia talk.

Senator BOYCE—Not yet.

Prof. Horgan—He is a real expert and he is very sensible in the things he says about statistics on suicide rates et cetera. When he lectures, one of the things he says is the suicide rates in any country in the world go down once doctors start using the modern generation of antidepressants, what are called the SSRIs—Prozac and then all its derivatives, the ones everybody uses now. The proof of that is that, when the SSRIs—Prozac and its cousins—were released worldwide, suicide rates dropped, except in Japan, where for some practical reason or other it took a year or two longer than everywhere else for the antidepressants to be released. So their drop in suicide rates did not happen until the SSRIs were released in their country. We had antidepressants before which were effective but had horrible side-effects, so nobody really would take them. The modern generation of antidepressants are effective but are tolerable; therefore, people are more willing to take them. There was a similar study, called the Gotland island study, done in Sweden many years ago, where the GPs were intensively trained in the diagnosis, recognition and treatment of depression. As a result, their use of tranquillisers like Valium went down but their use of antidepressants went up, hospitalisation rates were reduced and suicide rates were reduced. In any country in the world, if intensive use of antidepressants is appropriate, use of antidepressants reduces suicide rates.

The idea that help seeking is going to save your life is a bit naive, with all due respect. When people want help they then actually want something done about it. What they are saying is: I am suffering pain; please stop the pain. Telling them, ‘It’s good you’re seeking help,’ is not really going to make much difference in that sort of situation. Treating depression is like treating diabetes. If you have mild diabetes then things like exercise, eating sensibly and leading a proper lifestyle will help considerably. But if you have severe diabetes that is all a waste of time, to a certain extent, because your chemistry is grossly unstable. The reason antidepressants work is that they lock onto people’s chemistry. If we give the average person an antidepressant, nothing happens. But if we give people with depression an antidepressant we get radical change. The proof of that also is that pharmaceutical companies approach governments all over the world and say: here is our drug, we want you to buy it and it does all these good things. The governments then produce their own advisers, who will try to prove that the stuff does not work, to save money. But every government in the world buys antidepressants because the statistical evidence that antidepressants work is just overwhelming.

Senator ADAMS—How do we get to those people, especially rural elderly men, who do not use the internet?

Prof. Horgan—That is exactly the reason that we are in every telephone directory all over Australia. It is a 10-minute recorded message, the transcript of which is in the back of our original submission. Our statistics from Telstra tell us that people listen for an average of five minutes. That is a long time to listen to a telephone message. It shows people are not ringing out of casual curiosity. We routinely get letters from people saying, ‘Thank you, I’ve listened to your telephone message and you saved my life,’ et cetera. We also offer to send out to people packaged information about depression and suicide prevention. That has a questionnaire that they can fill in and take along to their GP. So, yes, we totally agree with you. These are people at high risk and we provide this anonymous service without embarrassment, which is what people want.

Senator ADAMS—Thank you.

CHAIR—Thank you very much. Your submissions and evidence are much appreciated.

Prof. Horgan—Thank you very much.

[9.45 am]

JENKINS, Mr Warren William, Board member, Victorian Mental Health Carers Network

Mr Jenkins—Thank you for the opportunity to be here. I am actually representing three different facets of the issue today. Certainly I am representing the Victorian Mental Health Carers Network because I am a board member of that organisation. You have a submission from them and I will talk about that. I am happy to answer questions on that. Secondly, I will talk briefly—or, if required, more—about my role as executive director of ARAFMI Victoria. You may have heard of ARAFMI. It is right across Australia—at least, in most states there is an ARAMFI or a variation of that carer support service. I am also a carer myself of a person whom I will talk a little bit about this morning if that is okay.

CHAIR—All of those things you have just said are okay.

Mr Jenkins—Thank you very much.

CHAIR—I understand you have been given information on parliamentary privilege and protection of witnesses and evidence. We have your submission from the network. If you would like to make an opening statement we will then ask you some questions

Mr Jenkins—I thought I would make a couple of comments and tell a personal story, if that is okay, because I think it illustrates some of what I believe are the key elements. It certainly reflects what is happening in that submission that we have given to you. I am going to be saying quite a few things that are different from what was said by the gentlemen who were here before me. I am not anti-psychiatry—I want to make that clear. I come very much from a partnership model of support services, medical services and clinical services working together, but I also come from a carer perspective where families are also working with mental health services right across Australia. As you know carers take the primary responsibility, in most cases, for people who have a mental illness. So there will be some things which I will say which may appear to be different but I am talking about specific situations.

I will talk firstly, about my own experience of about a year ago. I have a 36-year-old step son who has been ill with a serious mental illness which was diagnosed about 17 years ago. He is currently living with me and my partner, his mother. He has been up and down quite a bit. He is unemployed because he has not been able to get the stability for employment. He really has a pretty difficult and tragic sort of life but at the moment I am really pleased to say that he is probably the best we have seen him for 10 years. I can talk more about that later if we really want to.

About a year ago he was right at rock bottom and very desperate—very depressed. He was quite suicidal at times and talking about how life was not worth living and all these things. We were having a continuous dialogue with him about that and trying to give him assistance. He was rejecting most treatment programs. When he did receive treatment it was not doing anything, particularly, for him. Again, that is not an anti-medical statement; I am just saying that he did not find at that time something that was worthwhile for him in the treatment program.

Let me tell you what happened. One Saturday night—it was quite late—my wife and I were watching television and he came in very distressed: crying, upset and angry. He started screaming and took a big kitchen knife, which he held to his chest, and said that he was going to kill himself; life was not worth living. I am sorry; I do not talk about this very often.

It was certainly a very difficult time for all of us. We were listening, and it was a very distressing time for him personally but also for the whole family. What happened over the next hour was that we essentially listened to him while he held his knife to his chest. We obviously thought: 'What are we going to do here?' If we had called the police we would have escalated it and the whole situation would have gotten a lot worse. If we had called the CAT team they would have said, 'Yes, we'll be there within 24 hours' or 'No, it's Saturday night; it's almost midnight—you've got to bring him to hospital.' Those are the sorts of responses you would be likely to expect. So we were really on our own at that point. We basically talked through that with him. We went through it all. At the end of the hour the immediate crisis was obviously starting to shift. The pain was, I guess, still there but a little more controllable, and I was able to take the knife away and then say to him, 'Look, we need to go to hospital. We need to go to the emergency department and get some help. We just can't go on like this.'

So we did. We went to our local major eastern suburbs hospital in Melbourne, one of the best, where you would expect to get the best results. We walked into emergency, waited for a little while and explained the situation. Someone came down from psychiatric triage from the mental health service. What they essentially did was interview him, and me, briefly. We were there asking for help. The situation was that there were no beds. I know all the arguments and all the reasons for these things happening—no beds, it is better if he is kept in the community and all that sort of stuff. The best they could offer was that they were going to send around a CAT team or a worker within 24 hours to make sure that he was not still suicidal. In the end, I just said to the person—and this was after consultation with the psychiatrists—'What can you actually tell me to do? Give me some advice. How can I help this young man at this particular time?', and they said nothing. They did not know; they could not tell me. So we went home.

That particular incident, understandably, stuck in my mind quite a bit. It was not the first time he was suicidal. There have been a number of other times when I have had to go to hospital when he has taken overdoses or whatever. The points that come through for me are that, firstly, there was not a response at the emergency department at the hospital that actually assisted us as a family and particularly him as a person at that particular time. No-one sat down with him and said, 'Come and talk to me for an hour. What are the things going on at the moment that precipitated this, that actually got you to this point?' There was no crisis intervention strategy applied to him at that time.

Senator FURNER—Can I ask you what sort of communication was happening at the time of the intervention in hospital?

Mr Jenkins—Yes. They were asking a lot of questions about the severity of the situation. Obviously they came to the conclusion that he was not going to kill himself at that time, and I agree that probably we had reached that point. He had gone through the major crisis probably when we were home. By the time we got to the hospital we were looking for assistance but not going to get that. So there were questions like: do you still think you are going to kill yourself? Does that make sense to you?

Senator FURNER—Yes.

Mr Jenkins—So it was not around: how can we actually help you at the moment because obviously something terrible has happened or for you something terrible has happened.

Senator ADAMS—Was he on any medication at the time?

Mr Jenkins—On and off at that time. That was certainly a contributing factor, from my point of view. The other thing that happened, I would say as a representative of carers, is that there was nothing offered for me. I was quite traumatised by that myself, obviously. Why didn’t someone say to me, ‘Let’s sit down for half an hour and we’ll debrief about this. We’ll go through it and make sure you’re okay.’ Did I do the right thing, could I have handled it better and what was the best way to assist this person in this particular situation? On both those counts I felt the mental health service and that particular hospital failed to assist on that occasion.

You have got a whole lot of stories like that in that submission from us. Particularly I notice that the rural people probably illustrate that a lot more because of their isolation and the lack of services that they have. But these are the sort of things that I would be saying and our submission is saying. No doubt they were obligated to take him to hospital and admit him if there is a situation where they think he is suicidal at the time, even though that had just passed. I think he still needed to be given some intense support for 24 hours or whatever it took to make sure he was safe. There should be a lot more in the way of resources, and I am talking about personal resources. I am talking about staff, I am talking about beds for people who need them at the time. In my other role as executive director of ARAFMI we have a lot of support services we offer. We actually find that, yes, there is the personal element and the treatment element, going back to the first witness’s regime this morning. But often carers and people make contact with our service and sometimes they have never heard of a mental health service, they have just stumbled across our organisation and so there is that lack of knowledge; or they have come because they are receiving, or their son or daughter is receiving or partner is receiving, treatment from a psychiatrist and they are not getting the other element, which is the actual content, the actual conversation.

That is the other comment I would make, that while the immediate pain and distress can be relieved and hopefully in an ongoing way to some degree with medication, there have to be what people call the talking therapies, there has to be counselling. And it is very hard to get counselling. The Medicare rebate now which enabled it to happen enables things to be much better in terms of accessing that, but it is often not directly linked with people’s actual medical states, if they have been treated by one person who is a doctor and getting counselling somewhere else, though I am not saying it cannot work. We see a lot of that lack of what I call peer support, understanding. We have a carer helpline where people are ringing and we are able to understand where they are at. Obviously if there are serious situations where people are suicidal we are referring them on to a doctor immediately or to get some sort of medical assistance, but we provide what we see as a very valuable part of how people cope.

The other thing I would say is that once someone is on their medication they have actually got to make sense of life. The thing that maybe their mental illness or their experience has taught them is that they do not necessarily have some of the skills or some of the experience that are going to lead on to getting a job or getting a house or whatever. So there needs to be a whole of the work done, usually by families and carer organisations, to provide support for people. That is probably all I will say about my personal story. I am certainly happy to answer any questions about that. The network submission which you have got in front of you does in fact elaborate a bit more on that and give you some more information.

What we would be looking for is that hospital staff in emergency departments and mental health services as well are actually trained to respond in a positive manner and communicate with people who are suicidal and not to look just for the medication solution. That is certainly part of what happens, but everybody is aware that quite often the side effects of some of these medications are almost as bad as what people have been going through.

Senator BOYCE—Like schizophrenia medications.

Mr Jenkins—Schizophrenia medications and also some for depression, I think.

So we are looking for a greater amount of education for mental health staff but we are also looking for structures which allow families and carers to work more with mental health services. That is changing: in Victoria we now have carer consultants. But I am looking at back in the community, where people spend 98 to 99 per cent of their lives. They are not in hospitals; they are not at the doctor's—they are living their lives. That is where organisations like ARAFMI, who provide support, are able to come and meet a whole range of needs. I am not saying that we have all the answers but we are able to work with clinical services. We put a big focus on that at ARAFMI in Victoria. We work very closely with our regional mental health services and provide a complementary type role, so people receive not only their medical treatment programs but also some information about what recovery is about, about what it feels like to make the changes that you are going to make as you recover what is happening to you.

Senator BOYCE—Mr Jenkins, you mentioned carer consultants. What does a carer consultant do?

Mr Jenkins—In Victoria we have about 30 carer consultants. They are people who are carers, funded and employed by the state mental health service. They have a role of representing the carer viewpoint and making sure that carers are able to participate in the assessment, treatment and ongoing care of the people involved in the mental health service. Part of that involves meetings and education processes, but they also meet and represent people who are carers in the services and can give them information about how the service works, how you talk to a psychiatrist, what you can or cannot ask for and what sorts of things you can expect from the mental health service. It is about encouraging the case manager and people in the mental health service to involve carers as much as possible in the treatment planning, because they take a load of that responsibility once the person leaves hospital. That is the principle role.

Senator BOYCE—Where are they located?

Mr Jenkins—Usually in the mental health service. At, say, Box Hill Hospital, there is one based at Box Hill Hospital mental health service.

CHAIR—Are they located all over the state?

Mr Jenkins—Mostly.

Senator BOYCE—There are 30 of them, are there?

Mr Jenkins—Approximately, yes. That is my guess.

Senator BOYCE—So when someone comes into an ED—

Mr Jenkins—They are not actually based at emergency departments. They are based with mental health services—

Senator BOYCE—So it would be part of the triage that they would get—

Mr Jenkins—Not necessarily, no. Triage is normally a professional mental health worker who comes down from the mental health service or is based at the emergency hospital to do a clinical assessment of that person.

Senator BOYCE—I am just reading through your submissions. There are obviously lots of similarities to the disability sector, which I know a lot more about in terms of parents and carers being the ultimate expert but often being not listened to and perhaps even being seen as overanxious or in need of assistance themselves.

Mr Jenkins—Absolutely.

Senator BOYCE—How do we fit them into the suicide prevention strategy in a more focused and more mandated way?

Mr Jenkins—It is a very good question. I do not have all the answers. I will be talking more with a general mental health approach, if you do not mind.

Involving families—and carers in particular—is one of the keys. When someone is taken into hospital and admitted to a mental health ward or even the emergency department, it is like when I went in with my stepson. I quite clearly advocated quite strongly for him and for our points of view about what we thought was happening and what we thought needed to happen with his mental health care. They did not necessarily take notice of that, but we were able to do it. But when you get someone admitted into a mental health hospital or ward, because of workloads, routines and that sort of stuff it can be quite difficult for families to have a say. They may not necessarily be invited to the sorts of meetings where you can sit down and say: ‘This is what we believe is happening for our son. We know very well. This has been going on. That’s been going on.’ More typically, what happens in these particular cases is the medical staff will see it largely as an opportunity to bring the symptoms under control and therefore reduce the psychosis or depression for a person.

Senator BOYCE—It has to happen.

Mr Jenkins—Absolutely. What I am saying is there is also an opportunity for them to understand that person, to know why some of that has arisen in the first place and, once things have stabilised, to start working on some counselling or other forms of intervention than just medication.

CHAIR—A care plan or something.

Mr Jenkins—A care plan which involves carers having a say in what can be done. I agree that carers have their own needs. I know from my personal experience that I have my own needs which are quite separate from my son—

Senator BOYCE—How bizarre to have needs!

Mr Jenkins—That is right! But I see myself as a customer whose needs have not been met. I believe I have the right to say, ‘This is what’s happening; give me some assistance as well.’

Senator BOYCE—An issue that has come up is the misuse of privacy as a reason for carers and others sometimes not knowing what to do when you leave hospital. I understand that there is potentially available a care plan to include an agreement that has been signed by the person—say, with schizophrenia in this case—indicating what will happen when they are not well. Is that used? What are the privacy problems here?

Mr Jenkins—I think they are used but I would not say extensively. In Victoria they are being introduced. I forget the technical name for them.

Senator BOYCE—It is not an advanced directive but it is something like that.

Mr Jenkins—Yes, similar. I think—in my case, for example—it is more about having talked it through with my stepson and his mother, the three of us agreeing that, if this happens, if we say to you, ‘I’m sorry, but you are very ill; what you’re saying doesn’t make sense and we are very concerned about you,’ you will believe us. That is one of the difficulties. People are often unaware that, when depressed, things get out of perspective and they can become quite irrational. I think, when you are talking about a serious mental illness at the treatment stage, it is very difficult for people to know exactly what situation they are in. So the privacy thing is an issue. I know my stepson would say to the doctor and the nurses, ‘Don’t tell my parents.’ Why wouldn’t he? He is 36 years old and is trying to get a grasp of his own life and run his own affairs. So we have to say, ‘Yes, that’s true; we want you to run your own life too.’ I am sorry, but I do not have the answer to that one.

Senator BILYK—Thank you, Mr Jenkins, for your submission and for talking to us so openly about your own personal issues. We all understand that that is not easy to do, so thank you for that. I want to ask you: what sort of suggestions would you have for the committee in regard to what happens once someone has been discharged from a hospital, emergency department or whatever? Does your group have concerns or are they happy in regard to the follow-up, treatment and that sort of stuff? Could you talk to us a bit about that.

Mr Jenkins—Yes. We have very close connections with our clinical service providers and area mental health services, but we would think that that whole connection—that partnership between what is happening in the in-patient unit and what happens in the community—has to be much stronger and that there should be not only referrals but a handing over of a particular person. The family, I guess, are in the same situation. There should be a closer referral process. There are times when that does happen—people choose that—but, if they choose not to, we also run what is called a PARC service, which is a halfway, step-up, step-down facility with Eastern Health and the community. We are now just about to advertise for exactly what you are describing: a person who will be employed purely to follow up from the end of that process, so that, when people leave that intensive rehabilitation program that we have going, they will have someone else who will ring, make contact and hopefully visit to say, ‘Did you find you learnt something from that experience?’

Senator BILYK—Is that a live-in process?

Mr Jenkins—It is a residential program. It is only small—10 places. They are building them attached—or not attached but related—to the areas of most area mental health services in Victoria.

Senator BILYK—How many of those are there or are proposed?

Mr Jenkins—There are about seven, probably, operational at the moment. We have been running one for five years, which was one of the first ones to be established, and there are another seven or so that I think are being funded from about 1 July; they are doing the capital works.

Senator BILYK—So they are staffed by—

Mr Jenkins—They are staffed by—

CHAIR—I just want to check: how many places are there overall in those?

Mr Jenkins—There would be about 10 in each of those sites, I think. We are looking at about 140 or 150 people across the state. They are staffed by a combination of clinical workers—psychiatrists and medical officers. Clinicians from the mental health services come into our service on a daily basis to make sure that everyone’s health is okay, to answer any particular problems and to make sure their medication is functioning. Our workers who we employ—so we have workers employed by two different sources coming together—focus on how these people are functioning and look at a problem-solving approach: what is that they have needed to recover? What is it that brought them into this particular setting in the first place? Is there something that we can do to assist them? If it is a financial problem, are they getting financial assistance? Do they need someone to help them with their budgeting?

CHAIR—So you are looking after the social—

Mr Jenkins—The psychosocial rehabilitation component.

Senator BILYK—I am sure this varies greatly, but how long on average would someone stay in one of those facilities?

Mr Jenkins—Generally they can stay for up to a month, but the average stay is about 15 to 19 days.

Senator BILYK—You mentioned the issue of families also needing some support. Does the program that you run include the families?

Mr Jenkins—Yes, it does. What we do there is to run a combination of family and consumer—I will use that language—support. They are not necessarily the same families, because people want to remain anonymous. We get a lot of telephone calls on our helpline from carers who do not want to say their name but do want to talk about the situation they are in. They want to be listened to. They want to know that they have the latest information, and sometimes they will ring back two or three times, but we will just be providing them with information.

If we can, we will link them into our support groups that we run for carers and in that particular program that I was talking about, the psychosocial rehabilitation and the clinical program, the PARCS program, we actually make contact with families. It is with permission. We get the person to say that they do not mind if we contact their family. We reassure them that we are not going to talk about them; it is about what the family needs might be, and we see if there is anything we can do to assist them.

Senator BILYK—Just a general question, do you have a membership base? How many people do you think you—

Mr Jenkins—Yes, about 400 I think.

Senator BILYK—Do you get funding from anywhere?

Mr Jenkins—Yes, we do get funding. We get a mixture of funding. We have got approximately $2 million of state funding. That comes for three different things. The majority of it is for that PARCS program that we were talking about. We also get funding—almost 30 per cent—for our outreach workers. I do not know whether you have heard of HBOS, our Home Based Outreach Service support workers who are funded across Victoria to go to people’s homes and support the person with a mental illness, and also the family as well. We get a small amount of money from the state, under $200,000, for running carer support. We get a FaHCSIA grant, which is great, for respite development, and that is proving very valuable as well.

Senator ADAMS—I have a question about the emergency departments. How many of the emergency departments in Victoria would have mental health support, as in a triage person?

Mr Jenkins—I think that they all do now. I think that they all have to be able to see people who come into an emergency department within a certain period of time—though I am not sure what that time is. The triage person might not necessarily be based at the emergency department but they will come down from wherever the mental health service is—usually it is on the same site obviously—to the ED within a certain period of time.

Senator ADAMS—So the patient has access to a mental health specialist of some description in each emergency department?

Mr Jenkins—They should have, yes.

CHAIR—In terms of the issues around discharge—either going to an ED, in your situation where your son did not get admitted but left, and in situations where they do get admitted and discharged—we have heard some very disturbing stories in the other states about discharge with no support plan, no care plan, no follow-up. What percentage would you say in Victoria leave EDs, or leave admission from a hospital, without having any follow-up?

Mr Jenkins—I could not really answer that, but it is certainly not uncommon. As a mental health carer support agency we hear these stories all the time, so we would be reflecting the same thing, I think.

CHAIR—And in your son’s particular case they said that there would be contact within 24 hours—did that occur?

Mr Jenkins—It did, yes.

CHAIR—Was there ongoing support after that, or was there just the one contact?

Mr Jenkins—Right through this whole time he has had a case manager. They may not have very regular meetings but if there were a particular crisis then he would go back to, say, a monthly meeting with the case manager. I think that he is a very difficult person to support, so I would not blame it all on the case manager or the service. I think that it is quite difficult to provide.

CHAIR—When your son first became sick was there a place that you and your partner could go to find out how you could support your son, how you could cope with the issues that you needed to know about and the stress it put on you? Where did you go for that?

Mr Jenkins—As a matter of fact, we were living in Brisbane at the time—and it was about 17 years ago that he got his diagnosis—and ARAFMI in Queensland at the time was the only place probably where I could get that information and support. We made a decision when he became ill to come back to Victoria. It was for two reasons: firstly, because we needed to be nearer to our family for our own support and, secondly, because we knew this was where the services were—the non-medical, psychosocial services.

CHAIR—Thank you very much for your time and your submission. We very much appreciate it and we know how hard it is to come to a forum like this and talk about your own story. It is extremely valuable for us to hear it though so we very much appreciate it. Thank you.

Mr Jenkins—Thank you for the opportunity.

Proceedings suspended from 10.20 am to 10.36 am

YOUNG, Ms Leonie, Chief Executive Officer, beyondblue: the national depression initiative

KENNETT, Mr Jeffrey, Chair, beyondblue: the national depression initiative

CHAIR—Welcome. I am sure you both know the ropes, but I understand you have been given information on parliamentary privilege and protection of witnesses and evidence.

Mr Kennett—Yes.

CHAIR—We have your submission and your information packs. If you would like to make an opening statement, we will then ask you lots of questions.

Mr Kennett—Thank you very much indeed. We will probably both speak for about five minutes and then throw it open for you and your colleagues to pursue in any way you see fit.

It is a little ironic that we are here today talking about suicide and beyondblue, which is an organisation fundamentally about depression. The key that led to the establishment of beyondblue, in 1997, was the death of two young men in Western Victoria who were very good friends of my daughter, then a first-year university student. They were young men. Both died in totally unrelated car accidents. My daughter came to me and said, ‘What can we do to reduce the road toll, to stop these young men dying on the roads?’ I thought that it was about reducing the road toll.

When we started looking into the deaths of these two young men, we found that both had separated from their partners. One was engaged and the girl had decided to move to Melbourne to pursue careers that were not available in the bush—we hear the story so often. Both young men had used their vehicle to take their life. In other words, they were suicides, and they were not necessarily clinically depressed but they were emotionally depressed.

That led us to try and think about how we could address the issue of suicide numbers and depression. We came to the view that we were not going to be able to do much in the suicide prevention area directly because it would require a person standing beside another person 24 hours a day, seven days a week, but we could go back to the cause. Therefore, beyondblue was established in 2000, with the support of the federal and Victorian governments, to try and do a number of things, all of which contribute to the space in which your inquiry is seeking further information, being suicide.

We seek to destigmatise the illness so that people will talk and seek help. That is good because that will lead to the prevention of more serious illness and the prevention of more suicide. We do a lot of research, as you are aware—some into suicide. From our research, we deliver a whole lot of educational material. Some of the research proves up and gets introduced broadly. At the moment, we have the postnatal depression program being rolled out. It is a perinatal program for screening of pregnant women, and is very fertile—I made a bad choice of words there, maybe! More recently there have been programs with young people—secondary and primary, and we have just started a piece of work with children aged between one and five, not to find out whether they are depressed but to find out what is causing them to be stressed and anxious. If we can get to them and provide them with the tools early in life, then we are likely to see a better lifestyle for all.

I am now, after 10 years of leading this body, beyondblue, acutely aware that some people decide to take their lives and are not depressed. They make a conscious decision to end their lives, and I do not think we are ever going to stop that. Hopefully in the not too distant future we are going to have a properly scripted form of euthanasia. Life is so demeaning for some of us at certain stages of our lives that we would like an exit with dignity, as opposed to the suffering that we see. Some people will always include those people as ‘suicides’ by today’s definition, as opposed to people making a conscious decision to exit. But two-thirds of people who take their lives suffer some form of depression prior to them committing the act.

I am also, as a generalisation, very much aware of the value of education. The drop in suicide numbers—although there is some question as to the absolute quality of the numbers, because we do not always know, if a young male drives his car into a tree, whether he has had an accident or suicided—from about 18 per thousand to nine over the last 10 years is a remarkable achievement for the better. While others will argue that it is partly to do with the quality of medication, I am absolutely convinced it is to do with the quality of education and the transparency of discussions around illnesses generally, particularly as they affect men. That is not solely the work of beyondblue and we do not seek to claim credit for that. But we are one of the bodies in the field that have been trying to help people understand the ingredients of illness, to encourage them to seek help, to spread a message that says: it is not a crime to be ill; it is probably a crime not to seek help. That has put a lot of pressure on the professionals, but I have no doubt in my mind it is working to some degree.

I remain concerned with the abnormally high rates of suicide—and many copycat—in our Indigenous communities right throughout the country. It is an issue in Indigenous communities that no government has ever been able to address, not that there has not been the intent or the goodwill; we just have not struck the right mix. Sadly today, whether it is in the north or to the west, you still see a lot of it.

I am also worried about the impact on children of new media that sees them being subjected to comment, visions, pressure and bullying on the computer screen, their mobiles et cetera in the privacy of their own environment, where they are without parental guidance. That eats into some of these individuals, and there have been experiences down in Geelong recently where four young people took their lives in a very short period of time.

I have spoken to many who have attempted to take their own lives and not succeeded—some are quads, some are paraplegics, some are less injured—and not one of them has ever expressed to me the view that they wish they had died. They are just grateful they did not end their lives, regardless of their condition now. But the overwhelming view they express, as do many who are contemplating suicide in discussions I have had, is the phrase: my family would be better off without me. Somehow people see the impact of what they are about to attempt as making life easier for their families, which is where the education issue comes into it. You need to understand the mood that you might be in, if it is diagnosed early in terms of depression, can be cured; if it is a serious mental illness, with the correct diagnosis it can be managed. You will all know there are people around who have experienced serious forms of mental illness who live a very normal life but under medication et cetera. So this aspect, ‘My family would be better off without me,’ is part of, in the back of my mind, what drives our education. How do we give people the knowledge, firstly, that to remove yourself from a family environment leaves everyone else in pain and, secondly, that your family really do value you? At what stage medication and support come into play is terribly important and different in many cases.

There is one other aspect with the young—that is, a suicide is often responded to in such a way that other young impressionable children will see the response as being fashionable. What do I mean by that? You go to a funeral of a young person who has taken their life and, invariably, if it is a schoolchild, the whole school turns out. It is a big occasion. There might be a lot of tears and a lot of hugging et cetera but it creates an emotion and an impression in the minds of people. Again, speaking to some of the young people at ages 12 and 13, they think it is acceptable that suicide is a life option. It is just extraordinary. So when a young person takes their life and a school turns out in great numbers for some who are weak, who are under pressure, or who are stressed that actually only adds to the fuels of thought process.

I think this inquiry is terribly important in assessing what has been done. When you have a look at your own report, the details within it and the increase in expenditure I think you can have some confidence that with the work that everyone has done over the last 10 years in reducing the rate from 18 per 100,000 down to nine per 100,000 we have achieved a great deal. We can never accept though the concept that we will be suicide free; we will not be. What we can do is look at the two-thirds of suicides that are the result of a person being ill or feeling worthless and try to give them some sense of standing and pride in the value of life itself.

From my point of view it is a matter of continuing the process of education starting as early as possible but understanding that there are increasingly some ingredients in life which are beyond our control that make our task more difficult, things like Twitter, Facebook, computer environments where children do get bullied and where people lose their self-respect very quickly to the point of them wanting to take their lives. I know my comments are very general and I expect your questions will be perhaps in more detail. I will ask Leonie to make a contribution.

Ms Young—I reiterate everything that Jeff has said. You will see from our material and also from the questions as we respond that community awareness education is key but there are risk factors as well that need action. Awareness on its own is not enough. There must be recognition of those risk factors which are depression, substance use and trauma. I am sorry to say in Australia in 2010 they also relate to hospital care and discharge. Some of the risk factors for suicide that we can be doing something about are about improving access, improving care and, importantly, improving discharge planning. In every state that you visit from here on, I am sure you may be aware already, acutely ill people are unable to get mental health beds and severely ill people are being discharged often with no care plan, often without their families knowing and often without support around them.

You will not be surprised to know that within three months after discharge there is quite a high suicide rate within that population group. When we look at all the risk factors in the populations that we might address—we include young people, particularly men, and rural and Indigenous people living remotely and so on—all of those risks are something we look to do something about. The information is there, we need awareness but then very much we need action.

Then the actions, importantly, need to include a coordinated response across Australia with all the work that is underway in suicide prevention and depression with various mental health and support groups, ensuring that we have, if you like, a network of care so that there is a safety net in Australia that is more known and more accessible and there is less stigma about mental illness and, importantly, that the improvements that we make in our health reforms do improve services for people with mental illness. They have very poor outcomes at the moment and some of those dangers, as I have mentioned, are risk factors for suicide.

Senator MOORE—There are two areas I would like to get your comments on, both of which you mentioned in your opening statements. One was the issue around awareness and promotion. Consistently in the submissions we have received there has been a call for a more national approach to making people aware of the issues around suicide. Certainly the issues of stigma, which we covered in our previous inquiry, are there, but there seems to be a demand for a national response to this and to get information out in an effective way. We have heard much about the Scottish experience, and it sounds to me that that is mental health via *Taggart*—we hear a lot of that. Apparently it is very good; I have read some of the stuff. Beyondblue has carved out a niche, I think, in terms of community information. Some of the work you have done has been extraordinarily effective in getting targeted markets. Would either of you like to comment on whether a national campaign could be run effectively or would be lost in the general barrage of media that all of us are exposed to on a daily basis.

The other thing is coordination. You mentioned that as well and I would like to know your view of the LifeForce program, which is determined specifically to get effective networks across the country, and what role, if any, beyondblue should play.

Mr Kennett—I think the question of awareness is very important, but please be aware that beyondblue’s awareness in the community, which is now about 74 per cent unprompted, is very high after only 10 years but we have not paid for an advertisement. We get communities giving them to us. We prepare the ads, but all our publicity has been donated to the cause because people believe in it. That has been backed up. Although we are based in Victoria, we are national and we spend a lot of time travelling—Leonie and I particularly. I would have spoken everywhere in the country. I am going to Western Australia in a couple of weeks. Leone is going to Sydney and then she has something somewhere else. We are travelling every week. It is 10 years of being in your face. We have had very good programs in rural areas and good interaction with children; we are in sports areas and right across the board.

Then, if you are thinking about a message for suicide, the question is: what should that message be? I think it is actually about spreading a message that life is worth living. One of the questions I keep asking when I talk to people is: how many people today gave thanks for waking up? It sounds a simple question, but very few hands ever go up. I do not mean it necessarily in a religious way, but if you are religious so be it. Most Australians today take life for granted, and that is why, increasingly, more people, particularly children, are thinking that suicide is an option. So, if you are going to run a campaign which can then be badged as a suicide prevention campaign, I think it should carry a very positive message about the value of life rather than the negatives associated with suicide.

CHAIR—The message I got from people also was about reducing the stigma associated with suicide survivors so that they can get help. People talk about being alienated from work, for example. I also get the message that that is what people are looking for in a stigma campaign—to help suicide survivors.

Mr Kennett—I would say yes to a national campaign and know that, if it is well done, it will not be lost. But it is how you target these things. It is not just a matter of having a bowl of money and getting an ad agency to put something together and off you go. It may be that you can use some of the survivors. With due respect, I often use Nick Sherry as an example. Here is a guy who was so down that he attempted to take his own life and almost succeeded. He has come back and is now a very senior minister in government. He is one of hundreds of people in the country who have been in a difficult position and found themselves to have overcome and have then delivered.

If you are going to try and succeed, you have to have people who are known to the community in a broader sense. It gives you an entree straightaway. When I took over beyondblue everyone said, ‘You cause more depression than anyone else; it is appropriate you lead it.’ But people knew me good or bad, so it was a focal point. So you get a few people who can lead your campaign, and maybe you use a couple of the survivors. But you have to talk about the goodness of life, as opposed to the sulliedness of death. It could be done. And we do have a national suicide task force, do we not? It should be its task, perhaps, to do it.

This goes to the point you make about coordination. Right across the medical area in Australia we have hundreds of groups like beyondblue, not all as large, not all as successful. The duplication is enormous. Many of them are funded by governments, and sadly that is a waste. I have been arguing for a long time in an absolutely bipartisan way—and I know there are a couple of government members looking at it at the moment—that, if the government is going to give these agencies money to help them deliver their outcomes, it should also insist that most of them put all of their backroom requirements together. You do not all need accounting, HR and a whole range of services. You could save a fortune by putting a lot of the backroom services together, and that would then force people to talk more. We have over a hundred partnerships. We work with Suicide Prevention, we work with Alzheimers, we work with Heart and others very actively to try and eliminate the sort of doubling up that exists in society. But, even with that, it still occurs.

Ms Young—I want to give you my very strong view that having a national suicide prevention antistigma campaign is important, but not calling it a suicide prevention antistigma campaign in any way. Alison Anderson and I were working in Papunya in the Northern Territory before she was elected to the government. We had some funding for petrol sniffing, and she absolutely decried calling it ‘petrol-sniffing prevention’ or ‘suicide prevention’. She said it is like a club: if you call it that, people will want to be part of it. Whether there are high-profile people or otherwise, it is really important, as Jeff said, to build on the prevention, the awareness, the positives and then what we can be doing about it. That way, the stigma itself is addressed in the various things that we are doing, including our responses, those of the medical profession et cetera. There are a whole range of things to address the stigma but we must not call it a suicide prevention national anything, because we will have another group of agencies stepping up to bid for this. If it is the existing agencies then there will be this tagline or this very large banner that talks about suicide prevention, rather than addressing the issues at the community and the ground level for parents and other people.

Mr Kennett—I think that the drop in the suicide rate—and I say ‘I think’ because we cannot prove it—over the last 10 years has been in part because of the lifting profile of education about depression. It is going to cost you millions of dollars. We get tens of millions of dollars given to us every year. APN, the outdoor posters, give us gratis poster sites around the country. All the televisions, the radio—I have never seen such a wonderful coming together of the media to assist in a general message. We will obviously continue to do our work. That might still be the most efficient ingredient to retag that slightly or to try and change the emphasis. In the first eight years of my leadership of beyondblue, I was talking about what we were doing about depression in detail. But more recently I am giving at least half my speech trying to give people hope about the value of life, of living, of good health and of thinking beyond today and tomorrow so that the problems of today do not consume you.

I have realised, in doing these speeches, that while people come along to hear about depression—and in large numbers—we actually leave them at the end of the evening with positive thoughts to take away. So our role has already subtly changed. All this is good, preventative stuff. We have sent out 400,000 copies of *Taking Care of Yourself and Your Family* books—we give them free of charge—mainly to country areas. It is a very easy document.

I do not think, with due respect, that a finding of this committee that there should be a national campaign in itself is going to achieve anything because then it goes to the quality of the campaign compared to other things that are currently happening. You do not want a campaign just because it is an easy recommendation; you would want a campaign because you know that it was going to be consistently delivered—not just a media campaign but a campaign that is backed up by people who are out in the field, going to the town hall meetings and talking to the media—for 10 years. It is a hard ask, and then you have to have people who are absolutely committed to it, and for the right reasons.

CHAIR—If anybody has any other questions around a national campaign we will get those out of the way and then we will move onto another issue.

Senator BILYK—My question is around education, linked to the national campaign. I see that schools have a really huge role to play in trying to reduce the suicide rate but also in the acknowledgement of any sort of illness. As you say, it is criminal not to do something about it; it is not criminal to have an illness. I was just wondering whether you had any suggestions. There are various programs out there, of course. I do not want to sound too cynical about this but I do think there is an issue.

It is interesting that you mentioned that you were doing some sort of research into children aged one to five, to see what stresses them. I would be really interested to hear just a little bit more about that, although I know we are on a time limit.

Having a mental illness and suffering from depression, as you say, accounts for probably two-thirds of suicides, but there is a third of people who make that decision to end their own lives. I am not disputing the fact that people suffer from mental illnesses—I have had close experiences of that within my family—but there is an issue of resilience that we do not have any more. This is not a very clear question, I know, but I wonder what sort of views your organisation might have with regard to that sort of thing and education from a very, very early age.

Mr Kennett—That is exactly why we are doing the research. The work we have done in primary schools we tested in 105 primary schools throughout Australia—Catholic, independent, private and state—and it proved up very well after three years. It cost us about $5 million. The federal government is now rolling it out to another 450 schools throughout the country. The reason we cannot roll it out quicker is that we do not have enough trained people. We have to train people up to roll it out but I would suspect that if it keeps going it will be available to every primary school.

What is it trying to do? It is trying to give children the tools to deal with things that cause them anxiety and stress—the very thing that you are talking about: resilience. The work that we have started with one- to five-year-olds is trying to find out what the ingredients are that cause young people, to have stress and anxiety so early that they present to primary school already stressed and anxious. I feel very sorry for teachers. You might be somewhat surprised at me saying that, but I do because every time there is a social issue in the country people say, ‘We’ll fix this through the education system,’ and teachers, as you know, have increasingly become social welfare officers, and are not necessarily there to do their primary duty, which is teaching.

So we are trying very hard indeed to identify the stressors. And we think we have done it with primary schools. We think we will do it with one- to five-year-olds, but we will not know for three years, because that is how long the research will take. If we are successful we can arm these children with this knowledge and with these resilience factors that will stay with them for the rest of their lives. And in 20 or 30 years from now we might actually see a plateauing of the number of people putting their hands up with depressive illness. I am not saying that you will be able to stop it where there has been a shift in chemical balance, but where people become increasingly sick because they have the ingredients, as I describe them, of depressive illness, and do nothing about it, we can address that.

From our point of view, it is very exciting. I think that follows its way all the way through to people taking their lives—even with older men, if we can continue to educate them. There is nothing more satisfying than being at a town hall meeting in the bush where a male gets up. It has been a farmer on many occasions, but I remember one at a place called Ariah Park, out of Wagga Wagga. This guy got up and talked about his experience of depression. He was a little nuggetty farmer. No-one knew he had depression. He had never spoken about it. You could have heard a pin drop. That guy is now armed with tools. We use another farmer—recently I was somewhere in New South Wales; I do not know where I was—with his experiences. That will stop a lot of men then going out and, as they say, topping themselves. This education program is just so valuable, and that is the best campaign we have at the moment, really. It is continual, and we vary it from time to time so that we do not become complacent.

We have a helpline in place now that people can use from all over Australia, not just to get advice, but the people on the end of the line are qualified people to talk about their illness. We do not treat but we give them advice. We can arm them with that information. Leonie’s point is right: the further you live away from the city, of course, the fewer professionals and facilities there are, and it is a real issue. Even in the cities, it is very hard to get into places. If you want to go out to Odyssey House, out here, for drugs, but you happen to have an alcohol issue or a depressive illness as well, they cannot handle it. Invariably, there are no facilities that deal with a child or a person who has the three most common ingredients in a depressive illness, which are drugs, alcohol and depression. You never know where they come into the cycle, but they have got it. It is a very good campaign, even if I say so myself.

CHAIR—Let us do the education questions, and then we need to go on to other issues.

Senator ADAMS—Just on the research issue and looking at probably more Indigenous communities with the research that is now going into foetal alcohol spectrum disorder, is that included within your research as to behavioural problems and just what is going on?

Ms Young—Certainly we have a National Perinatal Depression Initiative which is looking at the stressors and depression in pregnancy and then after birth. That national program, with support from the federal government and all state and territory governments, is looking at a whole range of things. The foetal risks are, I think, also included in a national perinatal strategy as well, so they are being looked at and they are coming together. The simple answer is that they are being looked at, it is being included and it is being identified as a risk factor, but, as we know, it may take two to three to four to five to 10 years to actually get that improved practice in place, so having that run alongside awareness campaigns around drinking and depression is really important.

Mr Kennett—Was it Indigenous?

Senator ADAMS—Yes, because this is a problem in education. These children arrive at school and, until very recently, they have not been able to be diagnosed, so people think they are either autistic or just really bad kids. They cannot help their behavioural problems. The other problem is that there is not enough help at the school to enable people to be there to assist the teachers, so in the end these kids just drop out, so we have an issue. All of a sudden, it is being diagnosed. A lot of these kids do not have the facial features—I guess it is a problem in itself—but they are now able to diagnose them without their having those features.

Ms Young—Very simply, yes, those risk factors, and children presenting in early childhood and even at long-day care centres and kindergartens, are included in our KidsMatter Early Childhood and also our KidsMatter Primary Schools programs. Indigenous children and some of the specific risk factors that they are exhibiting are included in our KidsMatter program.

Mr Kennett—There is one thing with the Indigenous children in particular. We have programs with Red Cross out there working now. We have programs with artists going out there to attract the attention of the Indigenous children, to get them enthusiastic about something. A lot of the communities now reward their students with trips, so the children who attend most regularly will be able to come down to Melbourne to go and visit an AFL team. It is a very real connection with a lot of these young people. The difficulty is that there are not enough people on the ground all the time. They fly in, they do one thing for a couple of days and then they are out, and these children revert back to whatever it was, whether it was petrol sniffing or just not attending. It is a real issue, but there just is not the continuity of people. There are not enough people with the qualifications to service these young people. It is very sad.

CHAIR—I will move on to Senator Furner, and then I know that a number of us have questions in a number of other areas.

Senator FURNER—My question relates to grassroots initiatives or campaigns. I note that you have an agreement with Abigroup. I would just like to hear how easy or difficult it was to obtain that agreement with that particular industry and whether you have objectives to expand that to other areas.

Mr Kennett—We would love to. The Abigroup was very interesting. They came to us. They have a fairly progressive management. They are in a male orientated construction industry, with a lot of depression. If people are not alert, it can lead to accidents, death et cetera on site, so they have come to us and we are rolling out a program throughout all of their workforce. They have generously given us an amount of money, and we will get to all of their workforce over the next six to 12 months.

We do it with truck drivers. We have a partnership with truckies, and we are trying to do the same thing. We are very proactive in trying to get our message out into the workplace. Last week, or it might have been the week before, we presented to Rio Tinto. They want to do something. We are about to go and talk to BHP. We already do work at the tax office. We do work with the police. We do work with the defence forces, which is probably going to grow into a very major contract because of service personnel returning from overseas who are terribly disorientated, depressed et cetera.

We call it our Depression in the Workplace Program. We are just evaluating the value of it, as we consistently do. There are some very progressive leaders out there who are starting to understand that, if their workforce suffers from depression, alcoholism or drugs, they need to address it, and they are putting in place not only the training but also permanent systems. For instance, if you are with the ANZ Bank and you are a drug addict, they have a system with a clinic which enables you to go along—present anonymously to the bank—and the clinic will take you on board as a patient and try and work you through to good health. The bank will pick up the bill, and all the bank will get back is, ‘We had two of your employees here last week; here’s the bill,’ which is a very good way of operating. There are different methods, but there are some firms now that are thinking very differently about their workforce than they did a decade ago.

CHAIR—Senator Boyce, you wanted to touch on child suicide?

Senator BOYCE—Yes, I just want to follow up on that study you were talking about for the one- to five-year-olds. The question of a lack of focus on child suicide and a lack of knowledge about child suicide has been raised a couple of times in evidence. Can you tell me what beyondblue’s knowledge in that area is?

Ms Young—We look at the prevention aspect. We know that it occurs in very young children, and we know that sometimes it is relative to the environment, sometimes it is copycat and sometimes it can be a combination of things, like the opportunity.

Senator BOYCE—How do you know that?

Ms Young—From anecdotal evidence: families telling us or clinicians telling us that they have had to support a family with a suicide of a very young child. Many of the child psychologists and people working in the field are doing their best to address these issues early, and that is why the very best suicide—or stigma—prevention strategy is a campaign that is about saying that kids matter, improving the resilience and reducing the risk factors.

We do know a lot about those risk factors—we collect information and support research in the area—and certainly, looking at the research of the Australian Institute of Health and Welfare and the Department of Health and Ageing, there are a number of peak areas and key groups that have high suicide risk and high suicide rates. So we get a lot of that information and then look at the prevalence of depression in that population group, looking at the evidence about what the risk factors are and, very importantly, what would work. What is the intervening? What is the aspect? Very often it is education; very often it is support; very often it is around using the experiences of others to highlight what the circumstances were and then supporting people to make decisions early.

Senator BOYCE—Of course, we cannot know if we are improving suicide rates amongst children unless we know what the suicide rates are amongst children. New South Wales appear to collect figures only for 15-plus, which we spoke about with them yesterday; they are going to have a look and see what else they have. Queensland has figures for 10- to 14-year-olds as well. What is the Victorian situation, to your knowledge?

Mr Kennett—I think from memory it is 15-plus, but I think your point is a very good one in terms of collecting the information. As impure as the information is—because we cannot determine precisely—the more information we get, the better prepared we are at all times. Again, I can only say it anecdotally, but I deal with so many families and schools that have suicides in them, and I have done so over 10 years. Apart from where a child is a drug addict or gets influenced by alcohol—which is still the biggest contributor to suicide; young men in particular go out, have a few drinks too many and feel empowered to do things that the body cannot do, such as trying to jump from one train top to another or driving fast—there is no doubt that this issue of relationships is playing an enormous part, and a young person’s self-esteem is playing a huge part in their evaluation of their worth in life.

It is not something I noticed when I was growing up only a few years ago, but times are different. I remember suicides of some of my associates many, many years ago, but they were extraordinary. Today it is not extraordinary; I get calls three or four times a week from around Australia. It is why I come back to this issue: what sort of campaign would I run if I could? If I could get everyone to wake up every morning giving thanks for waking up, I reckon the suicide rate would drop another 50 per cent and the quality of health would be better. It is because we live in such a wealthy society, where we have never been put under any stress. We just take life for granted.

As I keep saying to people, the reason it is important to me is that, if you wake up in the morning and have said thanks because you value life, with anything that happens during that day you have a rock against which to measure the impact of that happening. Let us assume that, as happened a few years ago, I lose an election. All right, I was a bit surprised at the result, but, compared to the gift of life, how would you rate it? Probably only one or two. No-one died. It was a democratic process. It did not matter. My parents died; that happened in the normal order of life. Disappointing? Sad? Yes. How does it compare to the gift of life? Probably only two or three. If a child predeceased me, it would be up at the top end. If my football club loses the premiership this year, it might be 15! But having something to judge the things that cause you anxiety and stress, so that you can cleanse your mind before you go to bed and sleep, is terribly important.

Our children are not today given the tools to deal with life. That is not just a parental issue; it is a community issue. We talk about all these other things—climate change and everything else that excites—but, if we want to reduce suicide and depression and improve physical and mental fitness, we have to train our children and give them the tools to deal with life. For me, it starts with this concept of life itself because, against this rock, you can make decisions by the end of the day that will help you sleep well, and if you sleep well and get up fresh in the morning then you are lucky: you have another 24 hours.

Senator BOYCE—Of course to be able to wake up and be grateful for being awake requires that you are well.

Mr Kennett—It does in part but there are a lot of sick people who want to live. I have spoken to paraplegics who are never ever going to move and I said, ‘Are you disappointed?’ The answer was, ‘No, I’m glad to be alive.’ I know that is different from pain et cetera. But even a lot of people with pain still say they would rather suffer the pain and be here than not be here. What do you do with young children? I have now got three young grandchildren. Leonie has one and another on the way. Our minds are focused. If I do anything, it is to arm my three, and hopefully 10, grandchildren with this appreciation of life—the tools to deal with it. Whether they become politicians or tradesmen makes no difference but today most children do not have mechanisms for dealing with life. So when something happens that hurts them and it might be just an abuse of a feeling some run off, it blows out of proportion and they take their lives. Someone bullies them on a little machine and they take their lives.

CHAIR—We are out of time but I do want to ask about this issue around discharge from hospitals. From the evidence we had this morning Victoria sounds in a slightly better situation than some of the other states we have been to. We heard, I think it was in Queensland, that up to 80 per cent of people do not get support or they do not get followed up when they leave hospital or an ED. It seems to me that if we address the issue around discharge because that necessarily requires a care plan for a start but also a whole lot of other services there to make sure that people are seen and supported whether it is from a clinical or a social wellbeing perspective. Victoria is one of the better ones. I am told it is not fantastic but it is better than some of the other states. In WA we have some very significant issues and there are some quite well-known cases in WA. What should we be recommending?

Ms Young—There are very good step up, step down programs and there are very good clinicians who refer their people to a GP or a community health nurse or whatever their integrated care plan covers, so they have thought about it and they have steps in place. A really good model would include families. Many families do not know that their family member has been discharged and the first that they find out is that they are either acutely ill and have been readmitted or they have died. This is Australia now. We have a system called better access where you can go to any GP in the country and be diagnosed with depression, you can be referred to a psychologist for up to 12 sessions under a Medicare supported initiative. We could have something like that that followed the person. Whether you call it a voucher system or something else it would follow the person so that instead of relying on that variability of health services that we have you would actually have something for the person to use so they could purchase services where they are not in a position at the moment. To purchase those services means that they need to have some cognition about that or somebody helping them—a care plan—and we do not have that.

So it is about making sure the loops and the links are made, incorporating that safety net and building that into hospital admittance and discharge. You will see many, many hospitals and mental health services have reached their accreditation or they have the quality tick but do not measure the numbers of deaths from suicide within three months of discharge. I would say there is a groundswell of information that can assist us to make good decisions around that. Step up, step down programs are very good and they work in remote and rural communities as well, but you do need to have the health professionals in the area. That is something we do not have a great access to either so another issue is to improve the workforce in this area. They can be support people. They do not have to be triple certificate nurses, they can be community care people.

Mr Kennett—Many of these people who relapse do not need hospitalisation again. They need a sort of halfway house—so it does not use the whole resources of a hospital. They just need to go back to touch base, to be there for two or three weeks and refocus. Unfortunately, when they get out, either the effect of the medication while they were in the hospital has not been proven before they are discharged, because of the need for a bed, or they themselves give up on their medication. Then they fall off and experience difficulties. So we actually need some halfway houses that are not full-blown hospitals and utilise not necessarily medical staff, apart from one or two medical people, to oversee.

CHAIR—It seems to me that to get into hospital you have to be absolutely in crisis. We want to help people before they get to the crisis point.

Ms Young—Treating the depression, not the suicide attempt or the aftermath. You mentioned the ED. That is another area where a lot of people are turned away because there are not the numbers of beds. But where are they turned away to? We need to have something that just says where people can go—a halfway or a step-up or a pathway to care if it is needed. Certainly in community areas where there may not be hospitals, general practitioners—a little like teachers—are often the one hub and they are unable to manage the people that they have wanting to get in. So having more of a primary-level care system in our communities so that people and families can get the information and the health support that they need is very important.

Mr Kennett—One other thought, and it is a personal experience I am having now with a cousin who has got serious problems and has been put in a public hospital ward—and they have not been picked up by a CAT team. The rules, the legislation, the regulations, I think, prohibit private mental health facilities from holding patients against their will. In other words, you have got to voluntarily admit. You can leave a public hospital, where they have the power to keep you, and you can agree to be admitted, and the moment and you are there you change your mind and you are out, and then chaos starts again. I think that it would be a very creative thing—and I am not sure which are the rules or the regulations that govern it—that allows a responsible person who is responsible for the ill person to make a decision and that in the private hospitals there be a percentage of their space, not all of it, that could accommodate a number of patients under certain circumstances. There are some people with a lot of money who do not need the public hospital system, which is already overfilled, so allow that for the public patient. But if there were something in the provision of private mental health facilities to accommodate people against their will, as we do in public hospitals—for 10 per cent of their beds or something of nature—I think it would be a very advantageous addition to this suite of options we have and would lower only slightly the pressure on the public hospitals to allow other public patients in.

We would have admitted this woman to Albert Clinic or Melbourne Clinic in a flash. But they just said that they could not because the person, who is terribly ill—bipolar—and threatening people, has got to be able to say that she wants to be admitted. And of course she does not want to be admitted. She does not want to go anywhere. She thinks she is fine. So if there were someone able to look at that rule or regulation, I think that would make a great deal of difference.

CHAIR—That was included in one of the submissions. You read so many submissions sometimes that you forget who has actually written it. You just remember what they have said, and that is in one of the submissions.

Mr Kennett—It is well worth considering.

Senator ADAMS—Coming back to the rural areas once again, I am just looking at your rural workshops and I see that you are expanding those. How do you approach them and how do you evaluate them?

Mr Kennett—They are a major part of our work. They are not just for farmers, but for rural needs generally. We are working on a program to assist and to work with Mensheds to extend their reach, because men do respond. One of the great changes of the last 10 years is that when you go along to a men's meeting on health issues they turn out in absolute droves. That is a massive social change. You will often find that there are half a dozen women there but, overwhelmingly, there are men.

It is why we put in place our helpline. It is particularly for people in rural areas. Men in isolation can have, for the price of a local call, unlimited discussion times with a qualified person. So we are very conscious of this, the big thing that is missing in the bush. These will not be long-term services because increasingly, with the use of the internet et cetera, a person will be able to go along to a place and talk to a qualified person, who will look at it. But there have got to be facilities. If you are really in need—say if you need hospitalisation—you have to drive hundreds of kilometres. That often prevents a male from leaving the farm, because there is no-one else there to look after it, however much the wife might be trying to encourage them to take a break. So we are very conscious of it.

Ms Young—We have got the Don't Beat Around the Bush campaign, which, as Jeff said, really appeals to men. It talks to them frankly about depression and the signs and symptoms and what to do. Very importantly, we are working with the Divisions of General Practice right across the country in rural and remote areas on rural health forums—and we are working with LifeForce as well—so whoever is there can have access to the relevant materials and also the practitioners there who can answer questions if people can turn up for the meetings.

Senator ADAMS—What about local government?

Ms Young—Yes, we are working with local government.

Mr Kennett—There are a lot of suicides by men who have become separated from their families. It is part of the legal process. It is part of everything. We have done this in partnership with Relationships Australia. Again, if you have a look at the figures you will see there are a lot of men. As a generalisation, women seem to prepare better for separation. They are a little stronger. Men cannot handle it by the time the courts have dealt with them in terms of their assets and the division of access to children, if at all. There are so many such men. It is a very powerful group of people who feel really hurt and unfortunately many of them take their own life—as do Vietnam vets although I think we have now killed most of ourselves. There have been huge numbers of Vietnam vets who have just withdrawn from society, gone out into the bush and taken their own lives.

CHAIR—A last comment, Ms Young?

Ms Young—As Jeff has been giving illustrations: whether we are talking about schools or men in the bush or young children and suicide, each of them is a population group that has particular factors that increase the risk or it may be about where they are living. Those are the things that are compounding for them. Addressing the risk and doing more about resilience and less about the suicide and the focus on the end is something that we would very much recommend, so we would strongly recommend that. It is about looking at all of the population groups themselves and their particular risk factors and addressing those risk factors including discharge and so on. So that would be our strongest recommendation.

CHAIR—Thank you very much, Mr Kennett and Ms Young. We could be sitting here all day talking to you, as you have probably realised.

Mr Kennett—And we could with you too. Thank you all for this.

CHAIR—Your evidence and your submission were really appreciated. I suspect there might be a few questions on notice that we will send through.

Ms Young—We would welcome them.

CHAIR—Thank you.

[11.34 am]

AHRENS, Ms Jennifer Gaye, Manager, Integrated Primary Mental Health Service of North-East Victoria

PARISOTTO, Ms Laura, Early Motherhood Service, Integrated Primary Mental Health Service of North-East Victoria

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

Senator MOORE—Can you actually place your service in Victoria for us. We have got no Victorians.

Ms Ahrens—Albury. The geography covers the region from Mansfield through Wangaratta, Yarrawonga, Myrtleford, Bright—

Senator MOORE—It is all up in the country.

Ms Ahrens—Up in the country, rural and remote. Some of the areas do meet the criteria for remote. It may not be as remote but it is remote enough. It is Victorian remote.

I have prepared some notes to read so that I do not lose my nerve or forget. Working towards an effective welcoming front-end rural mental health service has been my passion for many years. I currently manage the IPMHS, which is a rural and remote service partnership between the north-west Victorian division of general practice and North-East Health Wangaratta. We have been operating since 2003. My colleague Laura is a clinicians in our perinatal mental health service.

My goal today is to draw attention to issues and solutions in rural mental health care and suicide prevention. The issues we confront are isolation, effects of long-term drought and fire, stoicism and stigma associated with mental health care. There are also a dearth of specialist services. While initiatives like such as better access have been fantastic in cities, they have not really hit the mark in rural areas because of lack of specialists and lack of money for the co-payment. In view of these issues, we have based our service on principles shown to assist in preventing suicide and improving mental health care. These principles are access, collaboration and resilience building, support and outcomes.

On access, GPs provide more than 10 million mental health consults per year. What better place for a mental health clinician to be situated. We co-locate our skilled mental health clinicians in general practices, providing free early intervention care in a stigma free environment. We also provide home-based perinatal services and have a clinician based in the local community health service. With our short-term funding for bushfire recovery and suicide prevention we provide active outreach, especially for men. We find are a lot of men in our rural areas who are picked up by the police or a community leader et cetera would not seek services, would not ring a helpline, but respond to the presence of another gentleman going out to speak to them. That has been incredibly helpful, because they are particularly reluctant to seek help. Falling through the gaps in care contributes to the high, 200 times more likely suicide rate following psychiatric admission. As part of the broader mental health service our clinicians are well situated to reduce this issue, facilitating effective care transfer and GP clinician follow-up.

Collaboration and resilience building: our community development staff work collaboratively with Anglicare, CALM, the CFA, the Department of Primary Industry and local councils and community leaders. It has taken us many years to penetrate communities, find the leaders and find the ways to better access that community. The reason is to facilitate targeted mental health program delivery. The programs we deliver include health screening at the saleyards, and that includes the local farmers, stock carriers et cetera, Pit Stop men’s health programs, to which we have added a mental health component, Coffee and Conversation in drought affected areas, which is our whole region, Women Gathering, and Mental Health First Aid and Youth Mental Health First Aid. These programs bring communities together, build capacity to recognise issues and assist help seeking and build resilience and reduce stigma. We have a very broad coverage of Mental Health First Aid in all our regional areas.

Support: an isolated autonomous workforce requires a welcoming, supportive team environment. We provide all day, every day phone support to our clinicians, flexible work conditions and weekly team reviews and psychiatry support. Even though we only have a psychiatrist for four hours a week, he manages to see clients that our clinicians are concerned about and provide GP support. It also provides a quality control, as the clinicians are not just out there operating on their own, they actually bring back case reviews and they have been scrutinised by a multidisciplinary team.

Outcomes: in both external and internal evaluations, high levels of client, GP and staff satisfaction with IPMHS have been demonstrated. Analysis of client health outcome measures shows significant reductions in symptoms and improvements in quality of living. Our cost per session is currently below the national average. That is measured on the Better Outcomes in Mental Health Care services, which is the bulk of our funding.

In summary, we are a service guided by the principles behind effective mental health care and prevention of suicide. We provide easier access to appropriate care in the right place, at the right time. Our service is currently threatened by uncertain funding in the Commonwealth Better Outcomes and the drought and suicide prevention programs. We need a long-term commitment to resources in order to continue our work.

CHAIR—Ms Parisotto, did you want to add anything?

Ms Parisotto—No, thank you.

Senator MOORE—Ms Ahrens, what are the terms of your funding now?

Ms Ahrens—Our funding for the Better Outcomes is until June 2011. The bushfire and suicide prevention funding is reviewed six monthly. Our state funding is secure.

Senator MOORE—The bushfire one is focused specifically on that issue, so you have to keep putting in evaluations to say why you think it is still required.

Ms Ahrens—Yes.

Senator MOORE—And the 2011 one is the standard three-year funding.

Ms Ahrens—Yes.

Senator MOORE—A lot of the stuff that we have been hearing in these submissions—and I know that you have been following them—is about coordination of services. When we did the mental health inquiry a couple of years ago, we had evidence from your part of the world about the need for coordination. One of the issues was the individual working with the client so that they know their client, they have a personal relationship with them and they can work through the processes. In your part of the world, do the hospitals have mental health facilities? Wangaratta does, doesn’t it?

Ms Ahrens—Wangaratta does, yes.

Senator MOORE—So anyone from the region who needed intervention of a serious nature would probably go to Wangaratta. Is that right?

Ms Ahrens—Yes.

Senator MOORE—Let us say that a patient is in Wangaratta. You probably know that they are there. When they are released, is there a service through your process that follows up on them? Does the hospital tell you that they are coming out?

Ms Ahrens—What happens now is that we have a person whose role is to undertake discharge planning and care coordination.

Senator MOORE—In the hospital or in your group?

Ms Ahrens—In the hospital. We are part of the broader mental health service. That person’s responsibility is to organise the discharge planning and to arrange for a follow-up. That could be through the GP, it could be through the community mental health service or it could be through us. It is their job to have that discharge summary out within 24 hours to the GP or to whoever is following up with the care.

Senator MOORE—How is that then coordinated within the area? With the Better Outcomes process, there is a very close link with Division of General Practice so that everyone works together and knows what each other is doing. It is always very dependent on the personalities of the individuals, as we all know; but, in terms of process, that is supposed to work. When someone has been released from hospital after an incident—we are looking specifically at suicide but it could be any mental health issue or any other health issue; for instance, if someone were released with a serious heart issue, you would have to know about that as well—are you confident that, under your model, there is continuation of service so that someone will not slip through the gaps?

Ms Ahrens—I could not say that I was entirely confident—

Senator MOORE—That was a harsh question.

Ms Ahrens—Yes. But I do know that there have been huge improvements within our mental health service and that it is reviewed regularly as to how the discharge planning is going, so there is a lessening of that occurring. As far as our responsibility is concerned, if one of our clients is admitted to Kerferd Unit, it is our responsibility to find out what the discharge plan is and whether we are coming back into the picture or whether it will be the GP et cetera.

Senator MOORE—And you talk to the GP?

Ms Ahrens—Yes. We are in the practices with them.

Senator MOORE—I know. I am just trying to get to that point. It seems that the model that you have got going is as good as you can get. Can you suggest any improvements?

Ms Ahrens—We have slowly, since 2003, built it up. Better Outcomes have been pretty happy with us. They have given us extra clinicians, so we can spread across the whole division. There is some scope to grow in the community health area. We have one clinician, because that is all we have scope for, but I think we should have more mental health clinicians in youth services and community health services, where you are working very closely with drug and alcohol counsellors, generalist counsellors and youth services. That would be a huge improvement to our service. Then there would be no barrier at all. The only barrier to access is the GP. Because of our funding, we have to go through the GP. So, if we could have referral directly from the client to the clinician, that would be even better. People do not have a stigma about going to a GP, and not very much about going to a community health service either.

Senator MOORE—How do GPs feel about that option?

Ms Ahrens—About us going into community health?

Senator MOORE—How do the GPs feel about not necessarily being the point of contact, so that people can come directly to you rather than through them?

Ms Ahrens—I think they like it that way. But you might talk to someone in a women’s shelter and they might say, ‘This woman needs to see someone, and we can’t get in to a GP for three weeks.’ So, whatever they want, it sometimes does not work in practice.

Senator MOORE—I know Senator Adams is dying to jump in, so on the clinical stuff I will hand over to her.

Senator ADAMS—That is certainly an issue in many rural areas: the books are closed, you have a mental health problem and you can come in four weeks time. It is hopeless. I would like to talk to you, Ms Parisotto, about your role and how many clients you see and the issues that you need to help you with what you are doing.

Ms Parisotto—I work in the GP surgeries. I am one of those clinicians. I am at one of the surgeries one day a week, on Wednesday, and I see quite a few people that unfortunately have to wait, sometimes for four to six weeks, to see me for an initial assessment. Once we have engaged, I find that it is quite helpful. With the GPs living in a small town, the communication is quite good. There will be someone in the GP surgery. A doctor will come out and say: ‘Laura, I have this client that’s in crisis. Could you see them now?’ I say, ‘If they’re happy to sit for 15 minutes, I can certainly see them.’ But how many people come through?

Ms Ahrens—Were you talking about the perinatal aspect of her work?

Senator ADAMS—Both, actually—perinatal and your other associated duties.

Senator MOORE—You are a psychiatric nurse.

Ms Parisotto—Exactly.

Senator MOORE—So that involves a bit of extra training to get the psychiatric qualification?

Senator ADAMS—Are you a midwife?

Ms Parisotto—No, I am not a midwife. Jennifer is a midwife. Even in the perinatal field, GPs will refer. They just have to pick the phone up and call us, and we can certainly see the women within a few days. That is the idea of the service—they can access it fairly quickly. We do home visits. That is the beauty of the service: often mums that are quite sad or dads that are home with their babies for some reason cannot come and see us, so we will go and see them. So we see quite a few people. How many would we see, Jennifer?

Ms Ahrens—About 180 a year. For the general practices, since 2003 we have seen 5½-odd thousand clients.

CHAIR—Overall?

Ms Ahrens—Overall. That is just the general practice. We started off with only two clinicians.

Senator ADAMS—Are your perinatal visits mainly for postnatal depression or has there been an underlying cause before?

Ms Parisotto—There can be—there can be a history of depression—but the majority are postnatal depression and a lot of adjustment into the new role of parenthood and motherhood.

Ms Ahrens—It is an antenatal service too.

Ms Parisotto—Yes. So they may have experienced depression in the past, but a lot of the time it is adjustment, with the component of depression in there.

Senator ADAMS—With your workload, which sounds fairly hectic, have you got any backup from the division to come and help if there is a crisis, especially looking at the bushfire issues and the drought?

Ms Parisotto—I have a colleague, Fiona Gladstone, and we job-share. So, one way or the other, there is one of us there in a crisis who can attend. If we are unable to access them within that day, we will ring community psychiatry and ask them for assistance in assessing that family.

Senator ADAMS—And you are able to do all of your follow-up quite successfully?

Ms Parisotto—Absolutely. Very much so.

Senator FURNER—The committee heard evidence regarding the intimate relationship between a member of the public in rural communities and, say, the GP in disclosure of mental health issues. I am wondering whether you are able to identify any of those impediments that may exist in someone coming forward and explaining where they are in terms of their health. The example given was that some guy might even be playing golf with his GP, so there would be a reluctance to come forth and identify the fact that they were suffering from mental health issues.

Ms Ahrens—That could absolutely be an issue. We do not place many of our clinicians in the town that they live in so that they are not highly familiar. That can be a real barrier. There is a fine balance between someone who is actually in the community and that you play golf with and someone who is completely alien. It is nice to have a bit of removal so that there is a variety of people that people can disclose to. It does not have to be the worker who is in your community.

Senator FURNER—What are these clinicians? Are they psychiatrists, psychologists?

Ms Ahrens—There is a range of clinicians that come under the definition of ‘mental health clinician’. They can be psychologists, social workers with mental health training, psychiatric nurses and occupational therapists with mental health training. We currently employ mental health nurses, a social worker and a psychologist. We also have a psychiatrist part time.

Senator MOORE—Can you fill the jobs?

Ms Ahrens—We can. It is a very desirable place to work and, unlike the rest of the mental health service, we do not have trouble filling the positions.

Senator MOORE—That is high praise.

Senator BOYCE—I suspect I know the answer to this, but could you clarify for us what a ‘community guide dog’ is please?

Ms Ahrens—Absolutely. The community guide dog is someone in the community who has a real feel for that community and its needs. They can say, ‘Go and talk to this person, that person and that person.’ They are your entry point into that community. The communities are all so different and there are different factions within communities, even more so since the bushfires. It has taken us years to identify people within the community who can help you target programs and help you to get organised and build those ‘guide dogs’ up to support us in providing the right type of care.

Senator ADAMS—Usually the busiest person in the community is the one you need to find. Coming from a rural community, it is a group of probably six or seven who are not busybodies but they know everything and they know exactly who to go to and it is just so helpful to someone coming in.

Ms Ahrens—Yes.

Senator ADAMS—I would like to move to the schools. What involvement do you have with the schools and are there any programs that you run there?

Ms Ahrens—As the primary mental health service we have a brief to see people from 0 to 100, so we see school-aged children. They are not by any means the majority of our work, but we do see young and adolescent people within the service. The brief to child and adolescent care and working with schools is with CAMHS, the child and adolescent mental health service. They offer a range of programs within schools which deal with bullying, anxiety—they vary at different times. They have some health promotion dollars and a part-time worker who works within the schools.

Senator ADAMS—Do they link in with you at all—that is, you are aware that they are coming and know about any issues they have that can be referred on?

Ms Ahrens—Yes. We have forums where all the mental health service managers get together and we can discuss the issues and the programs that are going on. Their health promotion worker is an invited member of our red group, which is our community development group, where we talk about our priorities for the year, requests that we have et cetera.

Senator ADAMS—Do you have a Men’s Shed in the area?

Ms Ahrens—Yes, we have one at Mt Beauty and one at Myrtleford and they are quite successful. Our Pit Stop men’s health nights are huge. We had one at Wangaratta and there were 350 men beating down the door to get in, which amazes me because they are traditionally such shy creatures.

CHAIR—Do they turn up in a ute here?

Ms Ahrens—Yes.

CHAIR—They all come to look at the ute!

Senator MOORE—I have a specific question. I am sure there have been suicides in your community in the last few years. What is your role when someone suicides? Are you called in and made aware? What would you do then?

Ms Ahrens—It depends. If the suicide is one of the clients of the mental health service, we have a process whereby we contact the family, because we usually know them quite well, and we offer debriefing. We also offer debriefing for our staff. We do not call it ‘debriefing’ anymore, but is basically an opportunity to ventilate and talk through the issues, for the staff and the family. If it is not a client of our service, we are often called in as the primary mental health team to talk to affected people. So, if it were someone in the CFA, the CFA might ask us to come and talk with them about what is going on. It depends on the relationship with the person.

Senator MOORE—Once again, it is often a stimulant to the contact. If it is already someone in your system, you would automatically be engaged, but if it is not you have to wait for somebody to contact you?

Ms Ahrens—Yes, and that comes through a range of sources. It might be the GP, the community health centre or someone ringing up and saying, ‘I’m really concerned about so and so.’

Senator BOYCE—You mentioned having meetings where you talk about issues for the region. How would you find out if those issues were similar to those in other rural areas in Australia and what they had done about them?

Ms Ahrens—There is no overall Victorian meeting or anything, but two of our clinicians have just completed masters in rural health, so we have kept up-to-date very well with issues in other parts of the state and the country, including the best ways of dealing with those issues. We base the service very much on the guidelines from the National Suicide Prevention Strategy—the things we know that help, like building resilience, early intervention et cetera.

Senator BOYCE—So it would be informal at the present time?

Ms Ahrens—Informal—yes.

Senator BOYCE—One of the things that keeps coming up is the number of programs, projects and things that are funded, but there is nowhere where practitioners in the area can go to cherry-pick the things that work or find out about the things that do not work in a national context.

Ms Ahrens—You have to seek it out with the beauty of the internet, I suppose, initially.

CHAIR—In terms of the discharge process, does each person who leaves hospital or an ED have a care plan? It sounds like you have a good system, but does each person have a care plan?

Ms Ahrens—Each person who leaves the primary mental health service has a discharge plan. Through the care, the GP remains what we would loosely call the ‘case manager’. The care is always to return to the GP. That is for our service. With the rest of the mental health service, there would be a discharge plan which would involve either a community mental health worker or someone who the person was seeing prior to the admission.

Senator ADAMS—How involved were you with the last lot of bushfires?

Ms Ahrens—Extremely involved. We left all our clinicians in place in the general practices, but our community development clinicians teamed to up with Ovens and King Community

Health Service, who were in the health service responsible for coordinating the response. We did an active outreach program to all the far corners of the burnt areas, sometimes in quite frightening conditions because there was still a bit of burning and so forth. We visited every family that we could locate in that area, making them aware of the services that were available. People were frightened and went to ground. People would come up and say, ‘So-and-so hasn’t been seen for three or four days,’ and you would find an elderly couple in a house in a burnt area. Active outreach was the way that we addressed it initially and then it moved onto case management for people who still required support. We also manned part of a recovery centre, providing mental health support in the recovery centre.

Senator ADAMS—So most areas had a contact and they were able to come back to you if they needed to?

Ms Ahrens—Yes. We gave them written and verbal information, because if they were not taking things in they at least had the numbers. We have designed what we call a mental health info card, which is a wallet-size card with all the crisis numbers and where to go for food et cetera. The state government put out really good information on how to seek grants et cetera, and we gave them all of that.

Senator ADAMS—That is good. Thank you.

CHAIR—Thank you very much. Your time and participation is really appreciated.

[12.02 pm]

OZANNE-SMITH, Professor Joan, Director, National Coroners Information System

PEARSE, Ms Jessica, Manager, National Coroners Information System

RANSON, Associate Professor David Leo, Clinical Associate Professor, Department of Forensic Medicine, Monash University

CHAIR—Welcome. Thank you for coming. I understand that each of you has been given information on parliamentary privilege and the protection of witnesses in giving evidence. We have your submission, thank you. I invite one of you or all of you to make an opening statement and then we will ask some questions.

Prof. Ozanne-Smith—We have a statement that all three of us will contribute to, but we will keep it very brief. I will start with some overview information. We will leave plenty of time for questions.

The National Coroners Information System is the only detailed consolidated system for coroner reported deaths in Australia, and it is relied on by the Australian Bureau of Statistics for the identification of suicide and self-harm deaths for the ABS's vital statistics function, so it has got a key role. The NCIS contains almost 200,000 national unit records of death since 2000. These are based on coroners' records and value-added with data from other sources. The NCIS is an independent data system based at the Institute of Forensic Medicine. It is governed by licence agreements with each state and territory department of justice and a board constituted by each secretary of the department of justice and representation from the Department of Health and Ageing. These organisations are also the funders. The NCIS data are used by government departments, statutory authorities, researchers, the media and coroners. So there is a wide range of users and this is increasing.

Our focus today in the inquiry is on term of reference b, the accuracy of suicide reporting in Australia. But we also wish to comment, briefly, on term of reference g, the adequacy of the current program of research into suicide prevention, and term of reference h, the effectiveness of the national suicide prevention strategy. I will be doing that wearing my research hat as opposed to that of Director of the National Coroners Information System. Jessica will introduce the key problems and recommendations for data collection and operational enhancements to the NCIS. David will discuss our key points concerning the coroner's determination of suicide and potential alternative approaches and then I will return briefly to the research issues. So, over to Jessica.

Ms Pearse—Thanks very much, Joan. Being the manager of the system I am just going to touch on a few operational issues that, in my role, I believe may have some involvement in potential underreporting of suicides.

The first item is that the NCIS is only as useful as the data that is collected and produced through the coronial death investigation. At present, there is no standard process across Australia for an investigation into suicide, particularly for the investigation at the time of death by police officers attending the scene. They collect a range of information about what they consider relevant and, depending on that variable level of information provided to them, a coroner may not have all the relevant information needed to help make a determination. Any method that would encourage more standard information collection—things like the deceased's history, any previous attempts and possible triggers—would assist in the best evidence-based determination being made by a coroner. It would also help with later research into risk factors, if that information is consistently being collected.

The second issue surrounds timely data entry into the NCIS. The distinction there is that this is not talking about the time for a coroner to investigate a death; this is—once the coroner has completed their investigation—the time it takes for that information to be entered into the NCIS. For the Australian Bureau of Statistics to have the most complete information when compiling official suicide statistics, data entry from coroners' offices into the NCIS needs to be timely. At present, there is a backlog of coding for some cases where the determination has been made by the coroner. Not all coroners' offices are currently able to complete coding on the NCIS within 60 days of a coroner's finding, which is our internal benchmark as to what we believe is reasonably timely. Sixty days is the KPI, I suppose, that we report to our board. This limits the information available to ABS when they are producing official suicide statistics and could therefore lead to various biases and underreporting.

Finally, there are some other issues associated with coding on the National Coroners Information System in that NCIS reflects any determinations made by a coroner about intent; however, where no determination is made, only extremely clear-cut cases can be coded on the system as intentional self harm. This also likely results in some underreporting of suicides. In some states, in fact, a formal finding about the death by a coroner is not required to be produced unless the case goes to inquest or it is considered to be in the public interest. It is the finding which is the document where any recording of intent would be made by a coroner.

The final system issue is that there is also no agreed distinction between the concept of someone meaning to harm themselves and then someone meaning to harm themselves with a clear understood intention to die. This further complicates determinations surrounding the deaths such as teenagers—did an 11-year-old actually understand the ramifications of their actions?—and those people with possible diminished capacity, such as those experiencing a psychotic event. I will now hand over to David to give a bit more information about coroners and their considerations regarding intent.

Prof. Ranson—Thank you. Because I was unclear to what extent you would have become involved with the coroner's processes in the inquiry so far, I thought I would outline some of the factors that take place along the lines of a coroner's inquiry. The mainstay for the investigation of death in Australia is in fact the treating medical practitioner, who provides the death certificate based on their knowledge of the patient. In about 10 to 15 per cent of deaths around Australia, the death is referred to a coroner, either by police officers or the doctor. Coroners, of course, judicial officers—they are lawyers, not medical people; they are people with legal experience in legal decision making. Coroners in fact manage the investigation of deaths, and in the case of suspected suicide cases will engage a variety of experts to help them—the pathologist perhaps to do an autopsy, a psychiatrist, witness statements from various people—but it is important to note that the coroner just does not receive all information from parties; they are in fact the manager of the investigation. So they can dynamically go out and seek more information if they believe it is necessary.

As far as the medical people are concerned, the pathologist in this process, we help by determining issues such as the physical cause of the death; the identity of the person, if that is relevant; but also the circumstances surrounding the death. So the autopsy is not just about the cause always but reconstructing what went on. That may involve integrating issues of drug levels, with dosages, with various physical activities and behaviours on the part of the person. Obviously those investigations do take some time and that time will depend upon whether there is going to be an inquest. That will involve public hearings, preparation of a brief of evidence and all the parties that might be involved. For example, a death in a hospital from a suicide might involve the hospital—the doctor being represented, the nurses being represented, the department being represented. So there is quite a complex issue for the court hearing, and that takes some time.

It is at the end of that process that this data finds its way to the NCIS. It is actually not an easy task necessarily for coroners to determine suicide. In some cases it may be straightforward, but, I think as Jessica indicated, finding that someone intended to harm themselves is not necessarily finding that they intended to kill themselves. That is an important distinction. There are a number of situations where it is quite problematic for a coroner to determine that.

To take one step back, we know from our own studies and our own research that there is underreporting generally to coroners. Indeed, the Registrar of Births, Deaths and Marriages in Victoria each year reports about 1,000 cases to the coroner where the doctor has not reported the death when they perhaps should have done. We have to investigate those cases in retrospect. Amongst those there will be the odd suicide—there will be the odd homicide, in fact. So this is quite an interesting mix of saying, ‘The community, even amongst the specialists, don’t always know what should be reported.’ Even when a case is reported there are problems with certain case types. For example, with an IV drug user—an illicit drug user, a heroin user—you do not necessarily know with an overdose whether in fact they intended to take their own lives. It could be quite difficult. It may be just the recreational use of the drug. A drowning at sea or medication in the elderly may be problematic. The elderly may be in a situation where they may be confused about medication and take an overdose accidentally—or deliberately. They may be found collapsed in their house and when they are eventually found have in fact metabolised an overdosed drug. It is not always very easy. There are rare occasions of deliberate concealment of suicide, and we also have the whole issue around the management of terminal natural disease and medications for pain and pain relief. These also complicate matters, particularly with families. And there is sometimes excessive risk-taking behaviour in the young.

Those are the sorts of issues that can make it quite difficult to determine whether a case is a suicide. In doing so, a coroner often has to balance the private interests of the family, the community or the cultural group with the public interests of the community as a whole in knowing what has happened when somebody has died. In one sense it is ironic that quite often, when a case is brought in, a body arrives at the mortuary and it is a case of suspected suicide, the pathologist will say, ‘Yes, we are dealing with this case as a suicide. The police have provided it to us as a case of suicide or potentially suicide,’ and I suspect that sometimes those initial assessments may be a truer reflection of what has really happened, even when compared to what has happened at the end of a very complicated inquest, where lots of parties have been represented to the coroner and portrayed their view of what has happened. Indeed, we need some research to see whether that is in fact the case.

Prof. Ozanne-Smith—I would like to make a couple of comments about the research relating to term of reference g. and the effectiveness of the national suicide prevention strategy, which is term of reference h. My concern in my Monash University role and as a longstanding researcher in the field of suicide prevention is that the current focus of research, research funding and organisational committees and their structures is on a mental health approach. Our research has shown that a mental health approach is not the only approach to suicide research. So, to some extent, people taking a different perspective have been excluded from some of these national processes. That is unfortunate, in my view. For example, there are other aspects to suicide research. Our evidence is that not everyone who suicides has a mental health condition, so using the NCIS data and other data sources we are able to identify other risk factors. For example, at the moment I am doing a study on work related suicide. We have found a very large number of cases in Victoria, which is where the study is based, where work stressors can be the most prominent factor identified in relating to why the person suicided. In the absence of mental—

Senator BOYCE—What do you mean by a large number?

Prof. Ozanne-Smith—In the dataset that we have established so far on work related suicide, we have around 500 cases over six years. We expect to refine that further. We are looking at proximal involvement of work related factors. Firstly, it is more distal, and by that I mean where somebody has a work injury and suicides or they lose their job and suicide or they get a redundancy package and suicide. That is pretty proximal, I would say. There are others where there might be three or four factors that have contributed to the person’s suicide, and work stress is one of those. We are looking at refining the dataset to include the more core cases, in which case we still expect to have 200 or 300 cases where we think that there may even be—

Senator BOYCE—That is just in Victoria?

Prof. Ozanne-Smith—Yes, just Victoria over six years.

Senator FURNER—While you are on that subject, could you identify the relevant industries?

Prof. Ozanne-Smith—We will be. It is early days with this research, but we think it is an avenue that has not really been researched. Also, this is just one other risk factor apart from mental health. I am giving it as an example of the importance of looking more broadly than just mental health conditions as the only approach to research. The other area of research that I have been particularly involved with over the years—and I know that David is very interested in this aspect, too—is access to the means of suicide. Suicide results from a chain of events and disruption anywhere on that chain of events can prevent the suicide. Not being able to access the means can make people rethink or use a less lethal method of self-harming.

Senator BOYCE—Could you give us some examples.

Prof. Ozanne-Smith—Some examples that have arisen out of the NCIS data recently is a spate of people going to shooting galleries and shooting themselves. For some reason the need to get a police report, which takes a couple of weeks, is bypassed and the person is allowed to go straight into the shooting gallery. They get a gun and shoot themselves. Proper regulatory control of those situations might prevent those impulsive suicides. If they have to have the cooling-off period of a couple of weeks to get their police report or whatever, or their shooter's licence actually granted.

Senator BOYCE—You are talking about people who are not mentally unwell.

CHAIR—You are getting into questions now. Let us finish the presentations.

Prof. Ozanne-Smith—Just one other example and then I will stop. Another recent example is where it has been noticed that there are quite a lot of helium related suicides—helium often used in combination with a plastic bag. Helium is an inert gas that is readily available commercially. We identify these means of suicide that become quite common. Again, a simple regulatory control would reduce these. In fact, one manufacturer is onto this already and is suggesting that he is going to introduce some oxygen into his helium mix so that suicide is more difficult. He is pre-empting a regulatory response to this particular issue. There are many, many examples of access to the means where it can be made more difficult, and there is evidence in the suicide literature that reducing access to the means reduces the suicide rate.

These issues about the research program are also reflected in the national strategy: it is not as inclusive as it might be of all the preventive approaches.

CHAIR—You said you wanted to address the strategy, and your last comment relates to that?

Prof. Ozanne-Smith—Yes, that is it. That is the end of our presentation.

CHAIR—Thank you.

Senator BILYK—Could you clarify for me—I have never seen a coroner's report: if the coroner was quite sure there was the intent to kill themselves, to commit suicide, would it say 'suicide'?

Prof. Ranson—The answer is that there is an enormous variation in practice amongst coroners. I have actually provided to the secretariat some documents—books and chapters—about modern coronership and where it is going. One of the issues that comes up is this issue: what do you do when a coroner forms a finding; what are they actually doing? There are certain statutory things they have to do. In some states it could be difficult for a coroner to comment on anything if it is not a full inquest, and the majority of cases are not held by inquest. Coroners will vary the way in which they use their language. Some will refer to the person taking their life with the intention to do so; some will make no reference to the word 'intent'. I think, Jessica, you did a study actually looking at what coroners put in their findings specifically about intent.

Ms Pearse—Yes. I completely agree with David: there is wide variation. Some will use the word 'suicide'; some will say 'meant to harm themselves yet cannot come to the conclusion that there was the intention to die'; others will say 'with the intent to harm themselves'. There is no real standard.

Prof. Ozanne-Smith—Others will be completely silent on the issue, so no intent is listed. Coroners' interpretation of some of the different legislations around the country can be that they are not required to make a statement on intent.

Ms Pearse—There is variation. If you talk to the different coroners in just the one state, they will have different perspectives about whether they will or will not make a statement in their finding.

Prof. Ranson—They are really a judicial officer, so they are balancing private issues for the family and so on against the public need to have certainty in some of these things.

Senator BILYK—Can you explain to us what the Briginshaw test is?

Prof. Ranson—The Briginshaw test is simply about the burden of proof that is required to come to a particular conclusion. While in criminal law we have 'beyond all reasonable doubt' and in civil law there is 'balance of probability', the Briginshaw is a sliding scale between those two. It says that the more a person is at risk, or the more serious the issue, the higher that standard of proof needs to be. In a coroner's jurisdiction, where they do not find guilt and they do not find negligence as such in a legal sense, if there is a party before the coroner who could be at serious risk of an adverse finding about what they did, then the evidence the coroner must use—before they can bring in such an adverse comment—would be of a higher standard than just on the balance of probability. So, the more serious the issue is for an individual or a legal entity, the higher that standard of proof. That is really what the Briginshaw test is about.

Ms Pearse—And that is applied in the context of suicide. Most coroners—and this is just my opinion—would appear to feel that making such a statement is a significant issue and does have ramifications for the family and life insurance and those sorts of things. So they would require that a reasonable degree has been met before they would make that statement.

Senator BILYK—Would that not make it very difficult to ever get some clear statistics on suicides?

Prof. Ozanne-Smith—It has been suggested in some of the submissions and in some of our thinking as well that there perhaps needs to be, as well as a legal level of evidence, a scientific level of evidence required. This is what researchers would generally be guided by. The level of proof for research might depend on a different set of criteria so that—

Senator BILYK—Can you give us an example of that?

Prof. Ranson—I suppose the simplest—

Senator BILYK—Are you talking about toxicology reports and things like that, or just—

Prof. Ranson—Yes, but I think if you are a researcher approaching a problem you usually have a specific definition: 'This is what I'm going to call suicide,' 'This is what I'm going to analyse,' or 'This is what I'm going to research,' and you set the research parameters for your particular study. In this situation, however, we have coroners working within different legislative frameworks around the country, with different personal viewpoints perhaps as independent judicial officers about what they consider to be a significant issue to call it a suicide, and sometimes really challenging problems. For example, let us say a very young, disturbed person was having an argument with their doctor—wanting to have treatment or wanting some particular medication—and in the course of that they say, ‘Well, you won’t give it to me,’ and then they start cutting their wrists or something like that. Let us say they then die. The situation is then: was that actually an attempt to kill themselves or an attempt to harm themselves to achieve a particular end or outcome, not necessarily death? And that can be sometimes quite challenging, and we will decide on different ways, depending on the evidence that is presented to the coroner—and maybe, at the end of the day, the coroner cannot be sure.

Prof. Ozanne-Smith—Whereas a researcher might say, ‘All cases of death where a person put a plastic bag over their head and supplemented that with putting some helium into that plastic bag I am going to define as suicide,’ a coroner may not.

Senator BILYK—Some of them might be death by misadventure, mightn’t they?

Prof. Ranson—That is right.

Ms Pearse—That is the difficulty. If you do not have one official legal entity making a consistent judgment based on consistent guidelines then it does mean that you have different people interpreting the data in different ways. And that does not really help when you are trying to get one consistent approach to a particular issue.

Senator BILYK—No standard process for police has been mentioned—I think you mentioned it this morning as well as in your submission. Do you think there is a need to standardise the process, to have some training for police who might be first on site and things like that?

Ms Pearse—I think we mentioned in our submission that our group has been involved in a project to try and get standardisation of the form that police fill in when reporting a death to the coroner, and about half the states and territories are using a version of that now. A form is one thing; to actually understand the reasons behind the importance of completing certain elements is another. I would expect that any sort of educational training for police would definitely be useful.

Senator ADAMS—I have a question to follow on from the length of a coronial inquiry and especially the impact it can have upon a rural community. An example is someone going through a fence with a loaded gun and the gun goes off. It is just terrible because so many people come up with rumours and there is the innuendo. It is just dreadful. The longer it goes on the worse it gets. The family goes through such a traumatic time, as do all the friends and everyone else. People think: was it deliberate or wasn’t it deliberate; how did it happen; why? The longer the inquiry goes on with no result, there is no end to it. Could you comment on that? Is this quite a common thing? Then could you go on to the coroner reporting back on rural incidents versus city incidents—the general type of thing that is happening.

Prof. Ranson—I could comment on the overall processes involved. As I said before, there is a big issue between balancing individual, family and community issues against the public interest in getting things right. In some cases the complexity of the investigation, with police reports, perhaps ballistic reports, reports from the local practitioner and perhaps some psychiatric reports, takes time. It is like developing a brief of evidence for any court, and court cases do take time in that process. The important thing is the communication that goes backwards and forwards with the family and the community during this. Certainly with the new legislation in Victoria, a great deal of emphasis is being placed on the continuing communication with the family and the coroner’s office having counselling staff and support staff to do that. The difficulty, of course—and I think you raise a very important point—is how do you bring all the complexity and therapeutic jurisprudence to play in rural areas where there is perhaps not the same resource base around the court structure? There is no doubt in my mind that there is not the same availability of that sort of resource in rural areas as there is in the main metropolis. It is quite true.

Ms Pearse—I could talk to the difference between suicide in rural areas versus urban areas. It has not really, prior to the NCIS, been easy to do. We have address information, based on postcodes, and we can geo-code that. One of the things that we hope to do is start to be able to produce maps, locality guides, of different rates in different areas. That might help confirm any possible differences in not only frequency but also perhaps different methods, trigger points and those sorts of things.

Prof. Ranson—The outcome of proper geo-coding is that it enables you to employ your resources more efficiently with regard to targeting the areas and sectors of the community that need the most help.

Senator ADAMS—I have a question on how Indigenous suicides are dealt with as far as cultural issues go. Could you comment on that?

Ms Pearse—I cannot really speak to the way that the coronial process handles those types of deaths. I can note that data collection at the moment in order to identify people who may or may not be Indigenous is relatively poor. It is a difficult issue. At this stage we cannot even confidently say, ‘This many Indigenous people committed suicide,’ because the question is not always asked.

Prof. Ozanne-Smith—One approach to this issue of not knowing much about Aboriginality is that we are interested in discussing with the Registry of Births, Deaths and Marriages some sort of data sharing about ethnicity and Aboriginality so that we can have that in our system and inform both coroners and researchers about this issue. But at the moment it is not always identified.

Senator FURNER—I am interested in the research you are doing on stress related illness and the link to suicide. I come from a background where I represented workers with stress related illness. My question relates to that time in the early- to mid-nineties when state governments started to tighten up the definitions of stress related illness. I think, from memory, it was an injury arising out of work, then it became a stress related illness and then it became a significant stress related injury or illness arising out of work. I wonder whether your research has identified changes in underreporting as a result of those sorts of circumstances in WorkCover acts.

Prof. Ozanne-Smith—To date, we have not looked so much at identified cases of work stress that have been ongoing. In the data we have so far looked at we have focused on where this issue is raised, perhaps for the first time, in the information gathered by the police or other witnesses at the time of death. We hope to link the research data we have for Victoria back into the WorkSafe and TAC compensation databases to see if these people did have a previous history of work stress or if they were on compensation because of a work injury, because there is also a group of people with chronic pain following work injury who suicide, largely because we are looking at avenues and ways of intervening to prevent these deaths.

Senator FURNER—Is it plausible that if there has been a tightening up of the definition of stress in a variety of acts around the country there could be an underreporting through the relevant workers compensation departments?

Prof. Ozanne-Smith—Possibly, but we have not looked at that.

Senator FURNER—Sure, thank you.

Senator BOYCE—It is good, Professor Ozanne-Smith, to have someone volunteer onto the record that mental health is not the only issue that we should be looking at with suicide. You spoke before about picking up trends in examples of the sorts of suicide that were happening, such as helium and a plastic bag. Where does that information go?

Prof. Ozanne-Smith—In the first instance we tend to alert coroners to emerging trends that we pick up. We pick them up in national data, so they might see only one or two in their state and not realise that it is an emerging trend.

Senator BOYCE—There are 20 that have happened.

Prof. Ozanne-Smith—Exactly, so we have a process of alerting coroners so that they can perhaps look at these cases—take them to inquest or make recommendations about them. But there is sometimes an astute researcher, who makes an information request to the National Coroners Information System, who has seen a case of this or has heard of this issue and is seeking the information for research purposes as well.

Ms Pearse—I would add that we also produce fact sheets if we come across an issue that we believe is perhaps not well known. We are not necessarily a research institution but we will compile a fact sheet.

Senator BOYCE—So that someone can come and research it.

Ms Pearse—Yes, we put it on our website to stimulate some discussion.

Prof. Ranson—There is also one other point that, in some of the new legislation, coroners now have the ability to publish their findings on the web directly—the new Victorian act does that. In fact, there may be a requirement for people to respond specifically to recommendations and those responses of key agencies that have been mentioned can also be put up on the web. So there is a bit of linkage now—closing the loop.

Senator BOYCE—That is what I was coming to with how formal or informal are the links that might get these sorts of things up in front of regulators.

Ms Pearse—We also provide a service for people who are not authorised to access the data directly, such as media or private organisations. We will do a search for them and provide them with some de-identified data. If it has come from a media outlet that will often be published in an article.

Senator BOYCE—We had evidence yesterday suggesting that there will be moves towards coroners mandatorily reporting to parliaments, governments or both. What is your view there? What do you think would be the best way for this to happen?

Prof. Ranson—The notion of mandatory reporting is an important one. Remember that the coroners court has a public audience—records of those proceedings are made, and they are recorded. Increasingly they receive far more publicity than they used to in the past. The question, then, is about the new legislation which requires people about whom a recommendation is made, that they should do X, Y and Z, to respond directly to that in writing and for those responses to be made public. I think that is a very important aspect of closing the loop. Of course at the end of the day it is still up to the executive to actually take notice of those things and develop the policy that goes behind achieving those changes. As long as the mechanisms are in place to ensure that information gets out then I think at some stage you have to close off and say, ‘The coroner’s job is to find those facts and to make those recommendations, but it is not their primary job to directly achieve that change in society.’ That complicates the judicial role somewhat.

Ms Pearse—As an addendum, because of the change in legislation—and I believe some other states and territories may be looking at a similar type of model—we are incorporating the ability to add responses to recommendations on the NCIS with some associated coding. So in future, if those responses are made, we will have a code that indicates whether the recommendation was fully, partially or not able to be implemented. Then, we hope, once you get enough data it will open the opportunity for research to say, ‘Okay, what sorts of recommendations are being implemented and, if not, why?’

Senator BOYCE—But this is not publicly available information?

Ms Pearse—On the NCIS, no, it would not be public.

Senator BOYCE—On a different subject, child suicide, we have talked about the problems with the data already. In Queensland a commission has been established to look at the deaths of children and adolescents. What are your views on child suicide, how well we are recording it and what else we might be doing in that particular area?

Prof. Ranson—It is difficult. There are not large numbers of child suicides. I think that they are cases that very easily do get referred to coroners, so there is not always going to be a degree of underreporting to the coroner, although—

Senator BOYCE—But there are the Queensland figures, for instance. I think from 2002 to 2007 the commission, going back and looking at coroners reports, came up with a figure that was at least 50 per cent higher than the ABS figures for the same period.

Prof. Ranson—Yes, and that may be a reflection of a number of things. I do not think it is a question of reporting into the process. I think children in that situation are reported to coroners.

Dealing with those issues sensitively in a coroners court environment and in a public inquest raises some very significant issues for coronial practice. It is not for me to say how a coroner should behave with regard to those things. As I said before, they are trying as a judicial officer to balance issues of private rights and privacy against what is said publicly, and that is an incredibly difficult task. It is unfortunate if, in carrying out that task, in the interests of the community, the families and so on, we do lack that sort of data which we really need to understand what is going on.

Senator BOYCE—Or the focus of an area, perhaps.

Prof. Ranson—That is right. And the issue there is that there must be other steps we can take—and we have raised some of these in our paper. Perhaps when we are recording these things through NCIS there needs to be different recording for research purposes than for that strictly legal public process. That distinction is probably a very important one. It takes nothing away from coroners in their role, which is critically important, but it also recognises that legal information is not the sole information upon which broader policy and public health things should be based.

CHAIR—There are a couple of issues that have come up that I want to follow up. One is that we were told in Canberra on Monday that the Victorian coroner is not giving details to the Registry of Births, Deaths and Marriages. Is that correct and do you know anything about that?

Prof. Ranson—I do not know anything about it in that sense. It is something I could certainly make an inquiry about for you. In any event, one of the functions of the coroner is to collect the information required by the Registry of Births, Deaths and Marriages to register the death, and they do that on a regular basis. Indeed, you cannot get your death certificate until that process has been finished, and my understanding is that death certificates are still being issued. So the data is getting there. What is recorded beyond that I cannot tell you at the moment. The coroner provides that information so that a death certificate can be issued. Death certificates are being issued. It is death certificate information, although the death certificate information does not necessarily carry all of those manners of deaths such as suicide and so on. For example, if someone is hanged or hangs themselves then the pathologist might say the cause of death is compression of the neck in circumstances of hanging. The coroner might give that as cause to the registrar and the registrar, with the other demographic detail, will issue a certificate to that effect. But that does not at that point talk about manner or how the person died or the circumstances. That is a matter for the coroner, not a matter for the registrar.

Ms Pearse—From the NCIS’s perspective we are still receiving all of the data from Victoria.

CHAIR—Ms Pearse, I have a question relating to this issue around timeliness of the findings and missing the cut-off date for the data entry, because we have heard about it several times now. In this case we are talking about suicide. If a particular suicide does not necessarily get counted in that year, does it get counted the next year? How is it an underreporting in terms of the overall numbers?

Ms Pearse—Historically—we are talking about up until pretty much the cause of death data, which is currently being released—my understanding is that the ABS would have their cut-off and then those figures would never be reviewed and revised.

CHAIR—All right.

Prof. Ozanne-Smith—So if there are some open cases—

Ms Pearse—So if you are looking at trends over time, you would look at the 2006, the 2007, the 2008—

CHAIR—So in theory if you do not make the cut-off in 2006, you do not then get counted in 2007—

Ms Pearse—Get incorporated in 2007. That is it.

Prof. Ozanne-Smith—But that has been changed.

Ms Pearse—The death would still be counted, but it may be counted as an unascertained cause or an accidental cause. Because of the acknowledgement of the huge impact that that is having, particularly in recent years, the ABS have changed their process and they are now, for the first time, involving 2007 data, I think it might even be this month or next month—

CHAIR—It is 17 March.

Ms Pearse—going to be implementing some sort of revision process, which it is hoped will then revise the figures that relate to that particular year. They will do that a number of times—I think they have committed to twice, but at the end of it they will say, ‘Right, how many cases are still open, a determination hasn’t been made,’ and then they can change their practice if need be to do further revisions.

Prof. Ozanne-Smith—They have also determined that instead of coding them by default to accidental, they will be coded by default to unascertained or undetermined.

Ms Pearse—And then that will be the holding area saying, ‘Right, we need to go back and have a look at these cases after a period of time.’

Prof. Ranson—Because there was a problem with the arbitrary allocation of those cases, many of them went to accidents, but stab wounds, for example, went into homicides, whereas in fact we do get stabbing suicides as well, so it had the potential to skew that data.

Prof. Ozanne-Smith—And the result of this process is that there is going to be a dramatic increase in suicide numbers in the next year of data that is released.

CHAIR—Thank you very much. Your evidence has been fascinating and much appreciated—and very helpful.

Proceedings suspended from 12.49 pm to 1.35 pm

STAINES, Mr Alan, OAM, Director, Hope for Life Suicide Prevention and Bereavement Support Services, Salvation Army

GALLET, Ms Wilma, Project Consultant, Salvation Army

MILLS, Ms Cindy, Private capacity

CHAIR—Welcome and thank you for coming. I understand that some of you have had experience of appearing before a parliamentary committee and you have been given information on parliamentary privilege and protection of witnesses and evidence.

Ms Gallet—Yes.

CHAIR—We have your submission. Would any or all of you like to make an opening statement before we ask questions?

Ms Gallet—Thank you. I will start and then Alan will say a few words. We have invited Cindy to talk about her story. The Salvation Army welcomes the opportunity to present to the Senate Standing Committee on Community Affairs and we want to particularly acknowledge the significant importance of this inquiry into suicide in Australia. The Salvation Army encounters people in deep distress in our work throughout Australia. Some of these people are homeless, some have serious financial issues, some are struggling with addictions, some have been diagnosed with mental illness, some are experiencing a sense of loss—loss of a loved one, loss of a job, loss of health—and many have lost all hope. Many of these people are at risk of suicide and we believe that we need to raise awareness throughout the community of the issues impacting upon individuals and families and, more critically, how we can each intervene to assist people to get the support they need.

The Salvation Army also operates a telephone crisis line which we call Salvo Care Line. It responds to over 120,000 calls each year and many of the callers to this line either are contemplating or have attempted suicide. We also work closely with people who have been bereaved by suicide. Many of the Salvation Army clergy support families immediately following the death of their loved one. They conduct the funeral and provide ongoing support and comfort through the grief journey. Salvation Army also facilitates a number of support groups in various locations throughout Australia. Through the Hope for Life program, which we represent today, we provide a range of resources, tools and training courses to equip people within the community to have the confidence and skills to provide support for people who have been bereaved by suicide. We also provide training in suicide prevention and recognise that postvention support provided to people who have been bereaved is also critical prevention support as research confirms that people who lose a loved one by suicide are sometimes at a higher risk of suicide because of their sense of loss and grief.

Salvation Army is concerned about the low level of awareness of suicide amongst the general Australian community. We recently commissioned Roy Morgan Research to conduct a nationwide survey into awareness of suicide amongst the Australian community. The results of the survey demonstrate that the awareness of the number of people who are recorded as dying by suicide each year in Australia is low, with only 14 per cent of Australians indicating that they knew the number and 34 per cent of Australians saying they had no idea.

Consequently, we support funding for public awareness campaigns and broad community gatekeeper first-aid type training, which will not only raise community understanding of the impact of suicide in Australia but also provide the general public with basic skills in how to recognise the warning signs and give them the knowledge to assist someone who may be at risk of suicide. We also support measures which will upskill members of the clergy, as potential first response support teams alongside police and emergency services, because of the evident gap we have seen in supporting loved ones at that critical moment when the death is first discovered.

Salvation Army would also like to see more support funding available to resource homelessness and drug and alcohol services to develop capacity and resilience programs to support people who are socially isolated and, in particular, disconnected young people who have limited family or personal support networks. In our submission we talk about a lot of examples of young people who have been in our homelessness services who have attempted suicide, and their experience in the emergency departments is such that often they are discharged without a holistic risk assessment that looks at their social supports.

We would also like to see greater coordination of resources following the admission and subsequent discharge of people who have attempted suicide. Some of the stories we have heard have been very critical of emergency departments and the lack of care available to people. We would like to propose that beds are available to enable the hospitalisation of people who are feeling suicidal so that those people can be observed, and to ensure that the suicide risk assessment conducted before a person is discharged also examines the physical, emotional and social supports available. Finally, we would like to ensure that there is adequate support when someone is discharged. Some of the stories from our crisis support line talk about a revolving door of people ringing the crisis helpline saying that they have attempted suicide. The helpline staff get them into the emergency department and they are calling back 24 hours later. So people should be given access to a 24-hour telephone number to provide them with immediate support if required. Alan wants to talk a little bit about some of our postvention initiatives.

Mr Staines—I welcome the opportunity to speak to you, Senators, comprising the reference group, particularly in representing the Salvation Army Hope for Life program. I, like other Salvation Army personnel, am passionate about providing services and support, particularly for those bereaved by suicide. We all know research statistics show that for every suicide there are at least eight family members, friends and colleagues who are closely affected by the suicide. Research has also shown that many bereaved family members are at high risk of suicide.

One of the key initiatives that the Salvation Army developed last year to recognise the grief and loss suffered by those bereaved by suicide was the national Lifekeeper Memory Quilt. I imagine some of you might have seen photos of the quilt. The national Lifekeeper Memory Quilt serves as a creative outlet for survivors’ grief as well as a touching visual reminder of so many who were lost to suicide. The quilt puts a face to suicide and helps carry the message that preventing suicide is not just about lowering statistics but also about saving the lives of mothers, fathers, brothers and sisters across our nation. Our goal is that we will hopefully continue to develop quilts, particularly in regard to states and territories in Australia.

People know that suicide is a problem, but the public still cannot fully comprehend how it affects every community in the country. The public still cannot put a face to suicide and cannot imagine how many of their friends and neighbours have been touched by such a tragedy. The creation and display of the quilt provides both a creative outlet for grief and a powerful visual representation of the staggering losses Australia suffers as a result of suicide.

It is an incredible quilt and had such an effect at our conference, which was held in Melbourne, in May last year. That is when the quilt was launched. It shows that those lost to suicide are so much more than a statistic, a number or a file in a coroner's office; they are real people with real lives behind these beautiful faces that are forever stamped on the hearts, minds and souls of those who loved them. As I said, the quilt has a huge impact on people. It acknowledges the lives which have been lost to suicide, the pain and loss, and the bereavement faced when losing their loved ones to suicide.

We also have the National Hope Line. Last year, we also commenced the National Hope Line for those bereaved by suicide. The number is 1300 467 354. It is available, operational 24/7 and is answered by trained volunteer counsellors. We find this is very effective, particularly in rural and remote areas where there is very little opportunity for support. People can ring the National Hope Line and speak to a counsellor who will be able to help and comfort them through their difficulty at that time. Wilma mentioned a first response service. I see a great need throughout Australia to develop a first response service for the bereaved when facing the unexpected trauma of losing a loved one through suicide. I believe the Salvation Army is in the unique position, with Salvation Army personnel located in most towns and cities throughout Australia. The primary reason why the Salvation Army has not commenced a response service is due to a lack of funding. We would like to initially commence pilot programs, particularly in Sydney and Melbourne.

I would now like to introduce to you Cindy Mills, who attended the second Australian Post conference when the National Lifekeeper Memory Quilt was launched. She lost her own daughter Victoria to suicide, whose photo is shown on the quilt.

Ms Mills—I was honoured that my daughter Victoria—who was 17 when she took her life in 2006, while we were living in Hobart—was a part of the Lifekeeper Memory Quilt, represented along with so many other beautiful people whom you would never expect to have taken their lives. It just demonstrated how random suicide can be. It is very powerful and overwhelming to see them represented visually rather than just as a statistic. I echo the Salvation Army's comments, and in particular Allan's comments, about the need for first response services for the bereaved by suicide. Thinking back to the day when I found my daughter it is like you are thrown into a completely foreign world. Police, the coroner, forensics all swarm onto the property. You are not even allowed into the property. It is very traumatic. It is like something out of CSI. I think it would have been really beneficial to have had somebody there who could have supported me through that traumatic and bewildering time that not only happens on the day but lasts for months while the police are doing their investigations because, basically, it is treated as a crime scene until proven otherwise.

Often, the police and detectives are not that sensitive, as I discovered, when dealing with those who are bereaved by suicide. On the day my daughter took her life I was handed a brochure from the coroner which was from another state and was told, 'Plenty of people do this.' Those were my only words of comfort on that particular day. It is a very lonely place when you are bereaved by suicide, because there are so many additional issues around the death. Not only are you grieving for your loved one but you are thrown into a world—a world I knew nothing about. I had not known anybody affected by suicide, so I had so many questions and thoughts that I needed to speak to somebody about who could understand what I was going through. Eventually, I was fortunate enough to relocate back to Sydney and found the Salvation Army Bereaved by Suicide Support Group. Only then could I meet with other people in my situation, in a closed group. It was a 10-week course where we could explore all aspects of our grief and aspects of suicide death. Nothing was taboo. We were able to speak freely in that environment and find the answers that we needed to help put the pieces of the puzzle back together and to start to get some sort of normality back into our own lives.

I echo Alan's comments and sentiment about the bereaved feeling vulnerable to suicide themselves. I had similar thoughts in the months and weeks after losing my daughter. Only when I found the help and support that I needed could I accept and feel comfortable with what had happened and continue to lead my own life.

I cannot express strongly enough the need for support services for those bereaved by suicide. As I said, it is a very lonely place. It is a highly unusual situation to be in where you find it so hard to relate to other people because most people have not gone through such a tragedy. It is just imperative that the services are there so that people can rebuild their lives and continue on, despite suffering tragedy and loss in that way.

Senator MOORE—These are questions to all of you, in particular to Ms Mills, because through this process we have been talking about the impact of suicide on families and the community. There seems to be a general agreement that there need to be services available through the whole process, immediately and going into the future. You did speak a little bit about the kinds of services you had, but if you—all of you—could get the services you think should be there, what would be the best model for working with those people who are 'bereaved' by suicide? Everyone comes up with their own terminology, but that seems to be the new one. I had not heard that before this process. If you could model what services should be available, what would they be?

Ms Mills—I believe that at the same time of the first call to the police—the coroner et cetera are all there on the scene very quickly—somebody who has experience around suicide, whether it be a volunteer or somebody who has been bereaved by suicide some time ago who is now in a comfortable place to be able to provide support to others, should be with you to explain what is going on, to offer comfort and to provide details of counselling services. I did not have any of that given to me. I had to seek that for myself and it was only because I was highly motivated to do that that I found these services. But what about the people who do not have that motivation or the resources to seek that out? I believe somebody should be there for them. You are locked out of the home. It was raining on the morning that I experienced this. It is absolutely horrific, and just to have somebody there to guide you through what happens next—for example, the coroner's report, interviews and those kinds of things. It goes on for months and months. I think the best model would be one where that same person can kind of ease you into the transition of what is basically a completely different way of life once you have been through something like this and can get you locked into a support service. I also think there should be more groups like the one the Salvation Army provides, where it is a closed, intimate group where you grow and move along with the same people, week after week. I have become lifelong friends with the people from my group. We continue to meet and support each other through anniversaries and things like that. It is so comforting and helpful to know that we now have each other, probably for the rest of our lives.

Ms Gallet—I think there should be something similar to what Cindy was saying. But certainly from that first moment when the police are called people should, at least, have access to a caregiver or chaplain who can be there—we heard some stories where people were held outside the house, and they needed practical stuff, such as a cup of tea, a coat or a blanket—then get the information. Immediately the police are called, Salvation Army officers and other members of the clergy are often contacted by the police, saying, ‘We’re going to visit a family; will you come along?’ If that could be a mandatory situation so that there is someone from the clergy or a caregiver of some kind to provide that sort of immediate support and then, as Cindy says, information about the coronial process and what is going to happen and what they can expect.

We actually run a training course for caregivers called Living Hope. It goes through that whole first response experience, how you secure the relationship with people who are bereaved. Often it is about just being there and being a listening ear and doing some practical things like making a cup of tea, getting a casserole or whatever. It is about that sort of practical support. As Cindy said, there should be ongoing support groups in all communities. Support groups ebb and wane depending on the critical mass and the synergy in the group. But it is important to at least have a core group there that is able to pull some people together to provide that sort of support. There also needs to be information in the form of brochures. One person who spoke to us said that the best piece of information he was given was—again, when his wife suicided it was totally out of the blue and a new world for him—a brochure that Centrelink had, and he found that the most helpful.

Senator MOORE—We very rarely hear that. I will pass on that we had a positive comment about a Centrelink product. We need to hear the good stuff as well, and I hope they got the information back that it did help someone.

Ms Gallet—Absolutely. The point is that not many people would know to look there. We have to raise awareness so that people know where they can go for help, whether it is a local support group or Centrelink. Maybe Centrelink or the Department of Human Services needs a repository of information. DoHA have the website Living is for Everyone and so on. That needs to be made well known outside the sector. A lot of these resources are known to people who work in the area, but we need to let the broader community know that there are these resources and websites available.

Mr Staines—I would like to see—and it is a big ask in terms of confidentiality—information provided from coroners about every person who has been bereaved. It is about not so much invading privacy but sending some information about where they can get help. I know this would create a lot of problems and a lot of coroners are not prepared to give out that information, but it would mean that, if no-one visits the person in a first response service, at least they have some contacts where they can find that help. The other thing is to get brochures in the likes of hospitals, funeral homes and doctors surgeries. When someone has lost a loved one and has not had that initial support, it would be helpful for them to be able to pick up a brochure with general information to support them through that traumatic time. They are things that we should be considering.

Senator MOORE—Has the Salvation Army been involved with the Support After Suicide project that the Jesuits have been funded for in Victoria and also the Mental Illness Bereavement Project that has been funded through SANE in Victoria? Have you been in network with those places?

Ms Gallet—Absolutely. We are aware of both those projects and have referred people to the support group that the Jesuits run. I think they run one in Richmond or inner-city Melbourne. Certainly SANE have been talking to us. We have done some cross-training where they have come and trained our crisis telephone line in the particular training course that they have developed around mental illness and suicide.

Senator MOORE—Ms Mills, obviously you have had the strength to actually step outside and be prepared to talk about what has happened to try and help other people. Have you been doing much work in this way? Is it something that you have been trained for? Apart from coming to confront a Senate committee, which in itself is pretty scary, have you decided that you want to do more in this field?

Ms Mills—Definitely. I have not sought these opportunities but I think that, through my involvement with the Salvation Army, I have linked in with them. Obviously, any opportunity that I have to help in some way I would want to pursue. I feel honoured that I have been given this opportunity.

Senator MOORE—Has that been helpful for you?

Ms Mills—Yes, I think it has. But I doubt that I would be in this position if I had not accessed the fantastic services that the Salvation Army has provided to me. That is what was so important to me a few months after losing Victoria. I knew I had a choice: either to never get out of bed again or to try to salvage the rest of my life for the sake of my other child. Thankfully, the strategies that I learned and the support I received from the support group have given me the strength to step out of my comfort zone.

Senator MOORE—It is a lovely piece. Thank you.

Senator ADAMS—I would like to go back to the start, really, to the confusion, firstly, when the event takes place and, secondly, to those left behind who are on the spot. I want to go to what you told us as far as when to expect the body to be released and the funeral. I have heard some dreadful stories where people have actually booked a funeral and, unfortunately, due to some hiccup—this is mainly in rural areas, where I come from, where things are made a lot more difficult. For an autopsy to be conducted, the body has to be taken back to Perth. Consequently, wherever that may happen, it may take a lot longer to get the person back for the funeral service. There have been some dreadful mix-ups in that respect where, the night before the funeral, people do not know whether their loved one will actually be returned. How does that work? What sort of process is it for the family, from when they are standing outside waiting to be told what to do? Is there anything?

Ms Mills—I was not told anything. Because you are in such huge shock it is only afterwards, months or years down the track, that you look back and think, ‘It shouldn’t have been that way.’ But at the time you are walking blind without a cane so you just go with it. There were so many aspects to what happened, and I wish I knew then what I know now.

Ms Gallet—Yes. I have definitely heard similar stories. I heard one story of a child who had died in rural Australia. The family was about 50 kilometres away. They were told, ‘Your son’s body is in the morgue.’ They did not have any transport. That is all they were told, and there was no way of getting there. The stories vary across Australia, but we have heard some horrific ones. One family talked about needing to talk through what happened and were told, ‘Go to the police station.’ They asked, ‘Can’t the police come to our home?’ They were told that they had to go to the police station. So there is no uniform compassion, sensitivity or process, in our experience, across Australia.

Mr Staines—Just as Cindy and Wilma have said, it reinforces the need for a response service. I have looked at a number of models. One of the models that is going very well is overseas. Frank Campbell was about the first to commence these sorts of services. They have a bereaved person who goes together with a professional person, so they go in twos. Not only can the professional person counsel the bereaved person; they can get alongside the grieving family. Having gone through the experience themselves they can relate to them and give them that comfort. The bereaved families realise that the person has been through it and is able to help them work through issues.

Senator BOYCE—At what stage are those people brought in?

Mr Staines—In the model in Baton Rouge, overseas, they are brought in with the police. They go directly. They call a number—for example, if we were doing it they would probably call the hope line number—and immediately connect with a professional bereavement person, who goes with the police to the scene. It is 24/7; you never know. Just imagine the number of suicides in metropolitan Sydney that happen because they have no support whatsoever.

CHAIR—So in that case the police would contact the agency to let them know, and they would then go with the police.

Mr Staines—That is right. It is a very successful model that is operating in Baton Rouge.

Senator BILYK—What sort of input does your organisation have with regard to family members feeling that somebody within their family is going to try to commit suicide. Do you have any recommendations for what can be done there or any general information for the committee?

Mr Staines—There are a lot of calls that come through to our Salvo care line. There are trained 24/7 counsellors on hand, and they generally assess the risk as low, medium or high. If it is high risk they will call the police or ambulance and get them to go to the scene.

Senator BILYK—This is if someone rings to say they are thinking about committing suicide? The question was about where family members might go if they feel that somebody in their family is at risk, as opposed to someone taking the extra step to ring.

Mr Staines—A lot of them ring the care line and get advice from the counsellor at that time, depending on what the circumstances are for that particular person. It could be that the person is intoxicated or has a drug related problem for which they can be referred to Salvation Army rehab programs. It depends on the individual’s circumstance.

Ms Gallet—The experience that we have had is that people struggle with the mental health system. It is very complicated. Generally, if you are approached by a family, the primary healthcare system seems to work quite well. The division of general practice has done quite a lot of training of GPs. It is when you get into the mental health system that people have said, for example, it depends on the psychiatrist you get, the system gets very complicated and people are sometimes given the wrong medication, it is too difficult to get on the right medication and so on. We recently did some work with a family whose son took his own life. He was only 17. They did not know where to go. There is a lack of awareness. Certainly, some people ring crisis help lines, but I think people are generally confused about where to go to get help.

Senator BILYK—How do you think the national prevention strategy is going? Have you had any input into that?

Ms Gallet—The programs that we run have been funded under the national strategy, and we can see that some inroads have been made into raising awareness. Cindy just mentioned to me that we run a gatekeeper course called Question, Persuade, Refer, which is an awareness training course for people to recognise the warning signs of suicide. The national strategy has seen greater funding of community groups, so the messages are getting out there, but we need greater coordination to make sure that it goes beyond the mental health and community sector. It has to get into all sectors, because it tends to stay very siloed.

Mr Staines—I agree with what Wilma is saying. I think there has to be a greater community awareness. A lot of people do not know and are reluctant even to talk to someone they think might be at risk of suicide, because they do not know the questions to ask. The program that we have been funded for by the Commonwealth Department of Health and Ageing is QPR, which stands for question, persuade, refer. It only takes an hour online to do this program. It educates people how to ask a question, persuade the person and then refer them. If they think the person is really at high risk, they stay with them. In many cases what has been recommended as the first port of call is generally the doctor so that the doctor can make a diagnosis in regard to the condition the person is in. If they think that the person needs further care, they can be taken to the hospital and sometimes even scheduled for psychiatric help.

Senator FURNER—One thing around this particular issue is what is involved in training someone to be competent in QPR and also what happens to the documentation as a result of relating to someone that maybe in a situation of mental illness. Is that documentation recorded and then is it passed on to other people to assist in their recovery if that is an outcome?

Ms Gallet—QPR is a very basic first-aid course. It is like CPR. Basically, it is an online course that takes one hour to do as Alan said. It is to raise awareness so that people will be able to recognise if someone may be suicidal and then it teaches them how to get the person talking about the issue. The recommendation all the way through is to get the person to their local doctor. It is not a certificate course. It is not an accredited course. It is just raising awareness.

Ms Mills—It dispels some of those myths that are out there such as, if you talk to someone about suicide that will make them suicide which seems to be a common myth. The QPR program dispels those damaging myths.

Senator FURNER—Is the record of the interview with the person established, maintained and passed on to, say, the GP as an example?

Ms Gallet—What QPR recommends is that if you have a loved one or a colleague who you identify as possibly being suicidal, take them to their doctor. That is the best response. First of all you ask the question, ‘Are you thinking of killing yourself?’ Generally, we find that people are relieved to hear that question. They open up and they start talking about it. The best response is not for this person to start counselling but to take them to their GP straightaway. If that is not possible, get a commitment from the person that they will go to their GP and they will make an appointment. It is basically like a social contract, but we are not training people to be counsellors.

Mr Staines—I think it is a very important tool in dealing with males. Males are very reluctant to express their emotions and when you look at the statistics, it is at least four to one in regard to completed suicides. Sometimes it is not until after the event that the family members realise that there were warning signs that they could have picked up. QPR makes people aware of the warning signs and helps them to be able to do something about it. Particularly with males, as I said before, asking the question, ‘Are you thinking about killing yourself?’ sometimes releases the opportunity to talk about it. In normal circumstances they would not say anything. It is a good tool particularly for those people who you think are at risk of suicide.

Senator BOYCE—In evidence it has been suggested to us that the Victorian ‘no wrong door’ policy is a good one. Could you tell me about the Salvation Army’s experience there? Do you notice differences?

Ms Gallet—Is this the—

Senator BOYCE—It is for mental illness. Does this affect intervention and postvention in a positive way in Victoria?

Ms Gallet—It would be a positive. The Salvation Army out in the west is co-located, I think, in the Visy centre, and there is headspace—

Senator BOYCE—Co-located with whom, sorry?

Ms Gallet—With the Visy centre—I think it is out in Sunshine—and there is a headspace facility there. It is like a one-stop shop. That model works very well for young people. It is a drop-in centre where you have employment agencies, homelessness agencies, legal people, health professionals and headspace. I am not as familiar with the No Wrong Door model or how that operates.

Senator BOYCE—My other question is this. During one of the breaks, one of the earlier witnesses mentioned that there was a special Magistrates Court once a week in Victoria for mental health patients who were caught up in the criminal system somehow. We do not have the

Victorian government coming to give evidence, unfortunately. I was wondering whether you were aware of that system.

Ms Gallet—No, I am not. But, interestingly, I know that there is a homeless persons Magistrates Court in Brisbane. I am assuming it would be a similar sort of—

Senator BOYCE—It is two sides of one coin—or half the side of similar coins, perhaps.

Ms Gallet—Yes, and it takes into consideration all of those sorts of factors. Mental health issues, of course, are evident in a lot of people who experience homelessness.

Senator BOYCE—That probably brings up the question that we have been asking all along—that is, how do we get mechanisms whereby things that are working well in one area get spread nationally or at least known about nationally?

CHAIR—That takes us to the question: do you know about Crisis Support Services—

Senator MOORE—The CSS.

CHAIR—the CSS?

Mr Staines—In Melbourne?

CHAIR—Yes. Do you have a lot of interaction with it?

Ms Gallet—Not a great deal, but we are hoping to. Again, I think it is very siloed. Looking at all areas of social policy, we still tend to see silos, even though—

Senator BOYCE—And you can talk about clinical as a completely separate silo again.

Ms Gallet—Absolutely. The whole social inclusion policy is around there being one door, or no wrong door, but there are different funding instruments, different jurisdictions and so on. We really need to work a lot harder at getting services to speak together both at a government funding agency level and then at a community sector level as well.

Senator MOORE—Are you aware of the CSS information hub as opposed to their normal service provision?

Ms Gallet—Yes.

Senator MOORE—Good. I just wanted to make sure, because we are trying to find out how well known that information hub is.

Ms Gallet—I think our knowledge of that is because we are a funded community provider. I do not know how well that is known more broadly.

CHAIR—How did you find out about it? When you say that it is because you are a funded body, is that because you are then part of a network?

Ms Gallet—Yes. As part of our funding arrangements with DoHA, there is an expectation that the various agencies that are funded under the National Suicide Prevention Strategy network together and look at some form of collaboration.

Senator MOORE—That is why we were told at one of the other meetings that someone knew about Inspire but then other people did not. It was written into your expectation of being funded and getting a contract that you would network with the other funded bodies. It makes sense.

Mr Staines—The other thing is that the Salvation Army have twice now convened the Australian Postvention Conference, and we try to bring all those other service organisations together to help in planning the conference. That is when we come in contact with a lot of these other organisations. A lot of them are on the conference organising committee and that sort of thing. That conference has been primarily for those bereaved by suicide, and that is where we launched the quilt, at the second Australian Postvention Conference. It has been amazing—the letters that we have received from the bereaved people who attended these conferences saying how therapeutic it is; they feel that at least they are being heard now. It is really a positive move forward in helping these people.

Senator MOORE—Are you funded for the conference?

Mr Staines—We have been given limited funding for the conference, yes.

Senator MOORE—It has been acknowledged in the strategy that the conference is part of the—

Mr Staines—No, it is not in the strategy. We have had to apply for extra funding.

CHAIR—As usual, we have run out of time. Thank you very much for your submission and your evidence. Ms Mills, we particularly thank you because we do know how hard it is to come and share stories in a public forum like this. Thank you.

Senator MOORE—Mr Staines, where is the quilt now?

Mr Staines—It is back at our office. It is a huge quilt.

Senator MOORE—We were told how big it is. We are hoping to see it, but—

Mr Staines—It is very difficult to transport it, so that is why we are developing state quilts now. They are much smaller, with about 24 faces on each quilt, and they will be much more easily transported. At any major event in any state that will be able to be on display.

Senator MOORE—Is the quilt displayed all the time, or is it just put away?

Mr Staines—It has been; it is not at the moment. We are just moving it into new premises, actually.

Senator MOORE—I was interested in the quilt.

Senator BOYCE—Thank you.

CHAIR—Thank you very much.

[2.20 pm]

KABAT, Dr Mirco, Director, Corporate Services, Royal Australian and New Zealand College of Psychiatrists

WATSON, Dr Darryl Peter, Member of the Executive, Royal Australian and New Zealand College of Psychiatrists

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

Dr Watson—Yes.

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

Dr Watson—We would like to thank the Senate for conducting this inquiry and considering the college's submission to the Senate Community Affairs References Committee on this important topic. The Royal Australian and New Zealand College of Psychiatrists is well placed to comment on this area of preventable deaths within the Australian community. We are the peak representative body for over 3,000 psychiatrists in Australia and New Zealand. We have the privilege and responsibility of training and accrediting high-quality psychiatry graduates to continue to serve our community. We work actively and collaboratively with government to improve pathways for international medical graduates to obtain specialist qualifications in psychiatry in Australia. We would like to thank the expert panel of members who contributed to our written submission on suicide.

Psychiatrists are medically trained specialists in mental health. Every day, psychiatrists treat people to reduce the risk of suicide. This work occurs across the life span from children to older people and covers a broad spectrum of mental disorders. Mental illness is the major contributing factor to suicide. Two-thirds of those who die by suicide have symptoms consistent with major depression at the time of death. People living with mental illness are much more likely to have serious suicidal thoughts than other individuals. These symptoms of psychiatric illness often occur in the background of complex biological, cultural, social and psychological factors.

Mental health problems are under-resourced in Australia. Burden-of-disease figures tell us that 27 per cent of all health disability is mental health disability. Only seven per cent of all health funding is mental health funding. The college recommends that the gap between the burden of disease and mental health funding be reduced. The resources provided for suicide research and treatment program evaluation are much less than funding for comparable conditions. Despite being comparable in terms of death rates, funding allocated to suicide prevention research is significantly less than that allocated to breast cancer. Evaluation of suicide prevention programs is essential. Without such evaluation, it is impossible to determine the effectiveness of suicide prevention strategies.

Service models for mental health are not standardised across the country. In our submission, we have described the key features of service provision required to provide an adequate service. We welcome the National Health and Hospitals Reform Commission report as a way of moving towards the development of a single, integrated health system without the complication of different governance structures. Reform is needed across the board. Mental health is a high priority, as it is already complicated by stigma, poor funding and complex social factors. We are also concerned for vulnerable groups using mental health services. This includes people moving between different services and those who self-harm. Diagnosis, treatment and community support services for these groups should be seamless and integrated. Patient centred, collaborative care is essential. Post-discharge support is necessary to maintain contact and follow-up after the event.

Suicide brings many negative outcomes. Families and carers bear a very high burden when grieving after suicide. I am sure others will be well placed to emphasise this point. With suicide comes a focus from statutory authorities and external bodies on negative clinical outcomes. The current nature of inquiries leads to a culture of blame and becomes a major distraction from ongoing service provision. Suicide is a common cause of mortality in serious mental illness. Therefore, the need for whole-of-system improvement needs to be better understood rather than there being a narrow focus of criticism on individual clinicians. It is important to ensure the accuracy of suicide reporting. The costs and demographics of suicide in Australia cannot be accurately determined at present and these figures are imperative for the development of effective strategies for suicide prevention. Improvements to the system of national suicide reporting require consistent, accurate, reliable and timely reporting in a non-stigmatising manner.

Work force is a key consideration. General practitioners treat the majority of mental health conditions, which is very appropriate. They are well placed to intercept mental health problems that may lead to suicide. People at risk of suicide come into contact with many different services. There is a need for improved training and education for those who provide these services. Ambulance and police officers are often the first responders to a suicide attempt. Education and training of first responders is essential. People working in education, social security and community services often see people in distress. Improved awareness of suicide risk factors and education to reduce stigma can be broadly targeted in this area. Mental health literacy should be a key skill. Indigenous groups, rural communities, refugees and asylum seekers require specific strategies. Culturally appropriate services should be proficient in recognising mental health issues and provide long-term care as necessary. Greater incentives are needed for mental health practitioners to live and practice in rural areas. Substance abuse is a major concern, as comorbidity with mental health issues is the norm. We need investment in more specialised dual-diagnosis beds and services across Australia.

Finally, I would like to express the appreciation of the college for the opportunity to address this hearing on what is a critically important issue for the Australian government and all Australians.

CHAIR—Thank you. Dr Kabat, do you want to make an opening statement?

Dr Kabat—No.

CHAIR—Okay.

Senator ADAMS—I will come back to alcohol and substance users. On page 21 of your submission, you say:

> Research demonstrates that countries which have a drug and alcohol policy have lower suicide rates, when compared to those which only have suicide prevention strategies …

Could you comment on that for us, please?

Dr Watson—That research emphasises the need to bring those two things together—that is, to not just have narrow-focus prevention strategies but to integrate that with this significant comorbidity issue around alcohol and substance abuse.

Senator ADAMS—For GPs or anyone training to be a psychiatrist, how much training is there on dual diagnosis and on cultural awareness? I am thinking more about the CALD group or Indigenous people.

Dr Watson—Standard psychiatry training in Australia is 60 months full-time work conducted in a broad range of venues, including mandatory attachments treating children and adolescents. In Australia, if you are working in the public mental health sector, where most of the training programs are, the prevalence of drug and alcohol problems is very high and in many of those places the comorbidity is well in excess of 50 per cent. Across those 60 months of full-time training, psychiatry trainees in Australia are confronted by treatment issues related to alcohol and substance abuse on a daily basis within the workplace. In addition, there is a mandatory training program that people must complete in their basic training in the first three years. It is required that an element of that be related to alcohol and substance abuse.

In terms of other groups that either represent disadvantage or are overrepresented in terms of suicidal behaviour, again by the nature of the work that our training psychiatrists do in an apprenticeship model, they are treating those things under supervision on a very regular basis. They are required to have culturally specific training—that is a mandatory training requirement—and there is a breadth given to other issues, such as those facing other groups with higher suicide rates, such as gay, lesbian, bisexual and transgender individuals. In terms of psychiatry training, we think it is relatively comprehensive.

Senator ADAMS—The reason I ask is that, on the dual diagnosis, often there have been complaints of, ‘This person couldn’t be seen because they had a dual diagnosis and no-one wanted to know.’ They had to have a mental health problem and the rest of it just got brushed under the carpet. Hopefully that sort of attitude has changed. Would you like to comment on that?

Dr Watson—It would strongly be the college’s position that that attitude should change. We have emphasised in our submission the need for better integrated service, for a breakdown in the confusing governance structures that many people work in. We have also emphasised the need for closer cooperation between those services specifically focused for people with drug and alcohol problems and those providing expert psychiatric care. We recognise with you that that is a problem and a major problem, and we are happy to work with governments and we are happy to work with others to help break that down further. In our training program, we are acutely aware of that and we think we cover that fairly well.

Senator ADAMS—We are only allowed so many questions. On emergency departments: probably some of the teaching hospitals have a triage person that is trained in mental health. Somebody presenting at an emergency department for general triage can be sent to that person or that person can attend to them. But how are the some of the regional hospitals and the smaller rural hospitals supposed to cope? Often that person may be disruptive and be pushed to the back of the queue while they deal with accidents and all the trauma issues. In a lot of submissions people have complained about more or less being ignored and then being given a few tablets and told to go home. Could you comment on that?

Dr Watson—We agree with your concerns on a number of levels. In our submission we emphasised the research that shows that many suicide attempters find their contact with emergency departments to be unfulfilling, stigmatising and negative in terms of future treatment contact. Your concerns outside of metropolitan Australia also are picked up in our submission. We would go further and say that those problems exist within urban Australia where we have problems in terms of 24-hour capacity to provide service, where there are deficits, such as those highlighted by the National Health and Hospitals Reform Commission, in the ability to provide outreach or in-the-community services across 24 hours. In terms of country services there are many disincentives to mental health practitioners living and working in the country. There are some innovative programs that look at that and we struggle to understand why they are not more widespread or better supported. There have been some initiatives in recent times that have assisted, such as Medicare funding for telepsychiatry, which in some parts of Australia is making quite good service headway. You are right; that is a major deficit within the whole-of-system organisation at the moment.

Senator FURNER—I would like you to elaborate on recommendation 26 in your submission relating to culturally appropriate services for asylum seekers and other refugees and relating to awareness of their particular issues at detention centres. They come from a variety of different locations around the world. How would you see that rolling out as a service?

Dr Watson—Our college has been critical of detention centres in what they do to people’s mental health and psychological wellbeing. There are specific problems with where those centres are based. For example, I know of a senior psychiatrist who is currently in Christmas Island and requires considerable travel time to provide services there. We have spoken out before about those issues. The complexities that arise are, as you say, the diversity of backgrounds in those centres and all of the usual culturally and linguistically diverse issues, the need for multiple types of interpreting services and the great difficulty of anyone who provides a service to the detention centre to be culturally and specifically attuned to all of those various groups. There are many psychiatrists who regularly provide services to one or two cultural groups for various reasons, but in the case of detention centres often, by the tyranny of distance, you are required to be there and have a great diversity of cultures confronting one.

In addition you have diversity in terms of people’s psychological wellbeing. Those who were psychological well before they got there and those who have been harmed by being there; those who are traumatised before getting there and the nature of trauma that many refugees experience goes well beyond that of usual comprehension within our community. The graphic and prolonged experience of torture needs to be confronted as well. We would see those as exquisitely complex places to work for all of those reasons. We are pleased that many of our fellows are doing that work, but we recognise a whole range of impediments to them providing that type of service.

Senator FURNER—Turning to self-harming and another area we have not touched on in regard to eating disorders. We heard evidence in Brisbane the other day that someone around the age of 50 upwards was self-harming, and that surprised me. I am wondering whether you have any evidence of self-harming in that age bracket and also whether you are able to comment on any links to mental health issues around eating disorders.

Dr Watson—Self-harming is a subtype when we think of research relating to suicide, and there is a group of people who chronically self-harm and the nature of the behaviour frequently brings them into contact with health services and mental health services. Commonly, if I can use the emergency department's experience, that creates considerable frustration by the nature of the chronicity of the problem. A common diagnostic group represented there is personality disorders, that is, lifelong disturbances of personality with their antecedents during childhood and adolescence. Because treatment for those conditions is complex, it does not surprise me that there are people reported to you at the age of 50 and beyond who have those problems. Many of those will be people with personality dysfunction and disorder.

We have focused on what is called serious mental illnesses—those with very high rates of suicide—in our submission. But of course there are great heterogeneity, co-morbidity and other conditions, such as eating disorders. Clinically, it would not surprise me to find self-harming behaviour particularly in individuals with bulimic symptoms. Fortunately, as treatments have improved in terms of acute eating disorders it is pleasing that there are people with chronic or remitting eating disorders into their 50s but we should not minimise that those people are often living with ongoing disability that may otherwise be hidden. One of the benefits of inquiries like this is that some of those less commonly talked about things get some air and public debate.

Senator BOYCE—We have heard in evidence a couple of times the idea that there is a very strong and direct link between abuse as a child and subsequent suicidal behaviour. Could you give us the college's view on that?

Dr Watson—Broadly speaking that is correct. We have emphasised the link with mental illness but that link goes several ways around the topic that you have raised. People who have been traumatised or who have had neglect in their childhood are more likely to have mental illness. When they experience mental illness that group are more likely to display self-harming behaviour and to suicide. The other complication there is in terms of co-morbidity—high rates of alcohol and substance abuse. There are high rates of accessing services but not necessarily receiving effective treatment due to the complexity of the problems. We would argue that a lot of those services need to have better access to expert psychiatrists. And then there are barriers in terms of those connections. You cannot have an inquiry into suicide without recognising that group that you have described. So I am pleased that they have been brought to your attention more than once.

Senator BOYCE—We have also had the suggestion this morning that Australia lags world's best practice in terms of prescribing for, particularly, depression by not using combination antidepressants when one appears to be failing to do the job.

Dr Watson—The college would support treatment guidelines coming from multiple places. These days it is quite possible for us to look at treatment guidelines generated easily in other countries. Treatment guidelines would strongly advocate, particularly during the early and middle phases of treatment, the idea of a single antidepressant agent for treatment. Within those guidelines and near the latter parts of treatment there is scope around combination treatments. But we would recommend those being conducted under expert supervision by psychiatrists who have experience in those things and access to other supports, such as the ability to test blood levels, perform cardiograms and the like. I do not think we would be supportive of early intervention with combination antidepressants in their strict definition. To clarify, often there are combinations of antidepressants with agents of a different class—

Senator BOYCE—No, this is—

Dr Watson—I am speaking specifically on the combination of antidepressants. So, yes, there is a role, but the role and guidelines are a fair way down the track in terms of treatment.

Senator BOYCE—What would your view be on the comment that that would in fact put us behind current world best practice?

Dr Watson—With all due respect, that would be a controversial comment.

CHAIR—The person who made it said that they knew it was.

Dr Watson—I suspect they may be a fellow of our college.

Senator BOYCE—They very well may be, yes.

Dr Watson—We are a broad church, Senator.

CHAIR—Would you go into a bit more detail about why? The person, whom you presumably know—and it is in the *Hansard* anyway—was making a fairly strong plea. He was not necessarily saying it would be at the beginning of treatment. He was saying that, if a medication is not working, the problem is when someone comes off and moves to another one and there is a gap, it may, potentially, cause significant episodes. Overseas, as one is fading down and coming off, they bring on the other one. Can you go through what is wrong with that?

Dr Watson—I think, firstly, to say that that happens overseas but does not happen here is a simplification. Certainly, I can take you to places—

Senator BOYCE—We want to give you the opportunity to tell us also.

Dr Watson—in the United States of America, where much more complex treatments occur commonly. In Europe, and in the UK in particular, there is a certain discipline around these things, a more stepwise progression around treatment. Usually, in clinical practice, if you are treating a depressive disorder with an antidepressant, you trial an antidepressant. The dose may be increased within the treatment guidelines or at the upper end of those treatment guidelines. Then, if you are looking at changing antidepressants, weaning off one and crossing over to another, it depends upon which antidepressant you are talking about and the relative safety of those crossover periods as to how long it takes.

In 2010, we are fortunate that we have quite a lot of agents and that you can safely move from agent A to agent B with relatively short washout periods. In terms of treatment around those washout periods, the potential of any benefit from agent A goes as you stop that but it is too early for a benefit to be gained from agent B, that calls for biological treatment benefits or other measures. So that would commonly be a reason why people may be admitted to hospital in order to reduce the suicide risk. Also, in hospital, there is a degree of safety accorded from a more rapid transition because you are able to have 24-hour, seven-days-a-week supervision and easy access to emergency services and the like.

What is the problem with the combination? All medications have side effects, and antidepressant medications have fewer side effects now than if I was talking to you 20 years ago. But combinations of drugs have combinations of side effects, and they are very poorly researched. So, while there is very good research on an individual agent used by itself, pretty good research on individual agents that have been trialled with other agents being in the system—for instance, common drugs such as those for blood pressure, diabetes and other common disorders—the research around combination antidepressants and its relative safety is markedly limited. That is the problem from that point of view. I think Associate Professor Horgan makes a good point: there are many people who require transition to other treatment trials, and that should be managed under expert care.

Senator BOYCE—I want to go back to the question of the silo, as we currently have it, and the sorts of things that you have talked about in having to strengthen the interconnectedness. I want to cover two perspectives. One is that we have already had evidence on a number of occasions that not all suicide is a result of mental illness. Where do we put that area of suicide? A second, related question but also slightly different—because I think aged care would be an area where there may well be suicides that are not related to mental illness. I was very interested in your comments that we need to evaluate attitudes towards euthanasia. Perhaps you would talk about those two areas, if you could.

Dr Watson—I think the first thing to say about both areas is we are research deficient on both of those topics. The area of attitudes to euthanasia, thoughts of death, suicidal thinking in the aged—particularly in aged males in this country with significant co-morbid physical conditions—is worthy of construable research and it is going to be an increasingly large part of our work with the changing demographic. There clearly are people who suicide where there is an absence of psychiatric illness. There is some argument as to how easy it is to determine those things retrospectively, but the research literature clearly identifies that there is a small minority where that applies. There is quite a combination of circumstances related there. For example, not commonly in Australia but in other places, political dissent takes the form of suicide. We can all think examples around that. Where do you place those groups? I think in terms of researching those groups, because they are a relatively small quantity they require specific consideration. What do you do with that group? What happens in clinical practice is if people attempt suicide they should be assessed and have expert review.

Senator BOYCE—They are assumed to be mentally ill.

Dr Watson—Not necessarily. The presumption is there is a high rate of mental illness. Mental illness requires exclusion in that group. A great many people who attempt suicide are not admitted to hospital and are not necessarily recommended further psychiatric care. That would be a standard event in any busy hospital emergency department dealing with people who attempt suicide. Probably the most common cases that we would see relate to acute social problems, particularly thinking about a relationship break-up and the like, and teasing those apart in a busy emergency department the morning after is quite complex but the sort of work our members do every day of the week.

Senator BOYCE—So what you are saying is it is more common to see someone who thought, ‘I’m going to kill myself because they left me,’ than—

Dr Watson—I think there is a substantial minority that fit into that group with an acute crisis. It is then a moot point whether those people have a diagnosable condition at the point of making that decision and whether that is a short-term condition that passes in a matter of hours or days. That would probably be the most common event that we confront in clinical practice.

Senator BOYCE—It would seem that if a person is 85, has two chronic conditions and is then told that they have a cancer or something that is going to be life shortening, it is not entirely irrational for that person to think, ‘Oh well, I think I’ll stop now.’

Dr Watson—The important thing about that is that those people are afforded appropriate care. Expert assessment, particularly in the very old group, by someone experienced in assessing older people or experienced in working in a general hospital situation is important. But just because life is difficult does not necessarily make death the attractive alternative. A great many Australians, including in the scenario that you painted, are confronted by great difficulties in life that at a rational level should make you consider whether death is a worthwhile alternative. We would argue that you need comprehensive, high-quality assessment to exclude the presence of a treatable condition and we need research around that group, which is likely to grow over coming years.

Senator BOYCE—Nevertheless, there is not a blanket suggestion that that is irrational behaviour in every case.

Dr Watson—I do not think psychiatrists would see that. The scenario that you painted is not an unusual one in clinical practice.

Senator BILYK—Does the college have any experiences in regard to families and carers of suicide victims, bearing in mind that a lot of the research I have read says that if someone close to you commits suicide it increases the chances of you maybe doing the same? Have you had any experiences in regard to what sorts of resources are out there for people and how people are dealt with by the police, for example, or other people they might come into contact with in the first instance of dealing with that original suicide? Is that clear?

Dr Watson—That is clear. In our submission we have not specifically addressed the connection across families in suicide. The common belief is the social restraint that a community imposes relating to suicide may be broken if a close member of your family has already completed suicide. We also know that the sorts of conditions highly associated with suicide have a genetic sharing across families. That is complex research work. In terms of families and carers, bereavement by suicide is a major issue. Those people do get assistance from psychiatrists and other healthcare providers over time. That is not an unusual part of psychiatric practice.

Senator BILYK—Do those people need to seek that help out or are they given information on where to go?

Dr Watson—If we are in contact acutely with families in these situations then they are always provided with options around places to go and supports available as well as ongoing support coordinated by that particular psychiatrist or hospital. I am not well placed to talk about the adequacy of those services across the whole country other than to say that in my own experience there are support groups and other services that seem to do a pretty good job in what is a very complex area. In terms of our specialist input, it is not uncommon for those family members to themselves develop a significant psychiatric problem that requires specific treatment after such a traumatic event.

Senator BILYK—We have heard evidence from quite a few people that they did not feel like they had any support base around them when a member of their family committed suicide.

Dr Watson—I think families and carers in mental illness in Australia are generally under-resourced and underserviced. In this area it would not surprise me that that was the same.

Senator ADAMS—You made a comment earlier about the funding for suicide prevention and how we get that up to the top of the scale. The actual counting of the number of suicides, as we have said, is very difficult because of the way the coronial results come in and what they actually say. How would you cost the cost of suicide? Wherever we have been no-one has been able to really come up with how much suicide does cost and what sort of funding would be needed.

Dr Watson—We have submitted that the data does not enable us to answer that question. The fact that you are able to ask such a good question repeatedly and people are not able to answer it goes to the scope of the problem. In terms of not knowing the number of suicides, what we can say is that the numbers that the coroners tell us are suicides are an underreport, so it something no less than that number. There is a bias in those numbers in terms of people in younger years, and there is a major cost in terms of lost productivity, preventable death and all of the other factors, some of which we have touched on here today. The fact that we are not able to answer that question goes to the problem around the accuracy of the data and the amount of support provided for that type of research. Australia has very good researchers in this area. They would be happy to answer your questions but they need the funding to do that commensurate with the funding provided to people in other areas.

CHAIR—The last question, which we always try to ask, is about the workforce: do we have enough psychiatrists in Australia?

Dr Watson—We are happy to train more psychiatrists. I need to put that on the public record because there are always people saying that we try to limit numbers and the like. We were delighted with the number of psychiatrists. The number of fellows of our college went over 3,000 a few months ago, so that is good. There is an increase in the number of medical students, and we are actively working with the Commonwealth to increase the number of training places for psychiatrists, particularly training places in high-prevalence of community based places. That puts a burden on fellows in terms of an apprenticeship type model. As long as those things are used efficiently, we would be very happy to work with governments, both state and federal, to increase the number of psychiatrists.

CHAIR—We have run a little bit over time. We have tended to do this the whole time because we get so involved in questioning each of our witnesses. Thank you for your submission and your time. It is very much appreciated.

Dr Watson—That is all right. We are always happy to help.

Proceedings suspended from 3.01 pm to 3.16 pm

ALLEN, Professor Nicholas Brian, Member, Victorian Section of the College of Clinical Psychologists of the Australian Psychological Society

McGORRY, Professor Patrick, Director, Orygen Youth Health Research Centre

ROBINSON, Ms Jo, Research Fellow, Orygen Youth Health Research Centre

CHAIR—I welcome witnesses from Orygen Health and the Victorian Section of the College of Clinical Psychologists. Is there anything you want to say about the capacity in which you appear here today, Professor Allen and Professor McGorry?

Prof. Allen—I should identify also that I do work at Orygen, and this is one of the reasons why we thought it might be helpful for us to share this session.

Prof. McGorry—I am also professor of youth mental health at the University of Melbourne.

CHAIR—I understand you have all been given information on parliamentary privilege and the protection of witnesses and evidence. We have your submissions. I would like to invite any or all of you to make an opening statement and then we will ask some questions.

Prof. McGorry—I will go first, Jo will fill out the Orygen point of view and then will hand over to Nick for the college of psychologists. I suppose the first thing I would like to say is that I think the fundamental problem with the suicide issue in Australia is the tremendous taboo and silence that surrounds it still. That is evident in something that probably Jo will talk about, the issue of the media guidelines. That is probably the core of where this issue has been debated. Absolutely it is a huge killer of Australians. It is up there with the road toll. As you would have seen from the Suicide Prevention Australia submission, there is an Australian dying every three to four hours from suicide and every 15 minutes someone attempts suicide. That volume of death and carnage is not actually in the public mind. The reason for that is that people do not discuss it openly and have been active attempts to inhibit that discussion, which fits in with this traditional suicide taboo that has been around obviously for centuries.

We are just starting to get to the point of challenging that now. We have had a situation where in my opinion the tale has been wagging the dog, this fear of copycats and contagion which actually is a small issue in the suicide risk area. It is debatable how much that is related to media reporting. Maybe a lot more of it is driven by local and other factors and, as Jo will probably elaborate, other new media. But no-one has measured the death toll that arises from not talking about suicide and not reporting it in an active way, in the way that we report on the road toll.

We do not report the road toll in a sensationalist way; we report it factually. We show the actual damage that is done to people’s lives and to the lives of survivors, and quite often that is done in relation to suicide. There was a *Four Corners* program a couple of years ago which showed the effects on the survivors around a 15-year-old boy who killed himself in Sydney, which would have been a tremendous disincentive to anyone even thinking of suicide. In relation to this issue and public discussion, we have to have it on the front foot all the time. We have to keep it in the public mind all the time. It has to be talked about much more openly.

There was another example recently, the young woman who was bullied to death in Melbourne. That was reported in a very good way. It showed how the risk factor of bullying contributed to the actual suicidal outcome. That is helping people understand how people get to that point. It also shows how suicide does not happen overnight. There is a common view, which you hear people give all the time, which is: ‘We had no idea that they were upset or distressed or depressed’, and yet psychological autopsy studies and every bit of clinical experience that I have had suggests that suicide does not happen overnight. The risk of suicide is lurking around in the background often for months or even longer, and something will trigger the actual final event. That is well recognised now, I think.

The only other general thing I would like to say before handing over to Jo is that I think the link between mental ill health and suicide has been seriously underestimated in Australia by the so-called suicide experts. There is an idea around in the community and in the mental health system even, or in the mental health community, that a significant proportion of people will kill themselves while in perfect mental health. That defies logic; it is the oddest thing that you would ever hear in the mental health field. We believe that 90-plus per cent of people who successfully complete suicide have been suffering from an untreated, partially treated or poorly treated mental health problem or mental illness. That is a myth that we really need to explode because it is important and because there is something we can do about it. There is something very preventive we can do, which is to actually put accessible, engagable mental health services and responses on deck to reduce the suicide toll.

I think we should set the kind of aspirational target that has been set for the road toll in Sweden, a zero road toll by 2020. We should set that kind of target for suicide deaths in Australia. We might not get there that quickly, but it would really put pressure on us as a society to significantly reduce the suicide toll as we have been successful in doing in reducing the road toll over the last couple of decades.

I might hand over to Jo to see if there are more specific things she would like to say.

Ms Robinson—The key aspect of our submission and our focus is that at national level there has been a failure to direct activity and priority to those people we know to be at greatest risk. What we do know, as Pat has alluded to, is that the majority of people who die by suicide are unwell; they have a history of mental health problems and a history of previous suicidal behaviour, be that a suicide attempt or deliberate self-harm. At national level there has been a failure to acknowledge that in the activity that has been funded under the auspices of the National Suicide Prevention Strategy. We would like to see a greater focus on those groups. Interventions for those groups can be more targeted and more readily subject to thorough and robust evaluation, unlike some of the interventions that have been funded to date that are more universally based and rely on things like building community resilience. They are very good things to do but are hard to measure and really are quite diffuse from the outcome of suicide itself. We are not targeting our resources where we would get best bang for our buck, I suppose.

As well, we need to be making sure that people with a history of suicide attempts who present to emergency departments and to services get proper assessment and proper treatment. We know that the majority of people do not and that the outcomes are better when people do get treatment. We need to be focusing some resources and some interventions there. There is a significant gap, I think, in service provision where young people, or people in general, I dare say, are at risk.

They may not be sick enough to get into tertiary services yet they remain at risk of suicide. There is a gap there as well that needs to be plugged somehow.

Building on from that there needs to be a system of monitoring of suicides in those groups. I know that the idea of monitoring or recording of suicides is one criterion of this inquiry in looking at completed suicides. What we also need to do is to look at suicides that occur by people who are under the care of psychiatric services or those who have presented for self-harm or suicide attempts. There are examples elsewhere. I used to work on projects like that in the UK. There have been precedents set where we can actually monitor some of the suicides that are occurring in those groups. We need to have a better idea of whether we are heading in the right direction in terms of suicide prevention here.

Again building on that, the other thing that is really lacking is a properly funded and coordinated program of research around suicide prevention. We know that there has been lots of epidemiological research looking at rates and risk factors and that is a good thing. But there has been a real dearth of research into intervention studies. There is some research that tells us some things that might be good ideas. If we have a nationally coordinated approach, what we can do is to have better resourced and better powered studies that can actually test interventions and we can learn more about what we can do in terms of reducing suicide risk amongst those people who are most at risk. We need a much stronger focus on intervention research in this country.

Prof. Allen—The first thing I would like to say because I am wearing a different hat to the others is that I strongly endorse the views of my colleagues here. I want to add to one thing that Pat was saying about the media reporting issue. Pat touched on this but I want to extend the idea that when suicide is reported there is often a strong emphasis on how the suicide was completed. The question that we need to be exploring as a society is why. When we understand why then it opens up all the issues. It opens up mental health, substance use, same-sex attraction amongst youth—a whole range of issues that are clearly relevant to suicide. This is the conversation we need to be having about the causes that lie behind these events. You can really find that out by looking at cases and discussing them openly.

To extend on some of the themes that Jo was talking about, putting my clinical psychologist’s hat on, what we would point out is that you can think about suicide as having two components. First of all, the person has to have the desire for a suicidal act and then access to the means to complete it. A lot of the more effective public health interventions have really addressed access to means and they are the ones that have been effective. Things like blister packs on medicines for example and things like that. What is less well addressed for all the reasons that have been articulated is dealing with the suicidal desire in high risk groups. In this area the main interventions that have an evidence base supporting them are psychological interventions such as cognitive behaviour therapy for example. Certainly, they have much more evidential support than universal preventative intervention approaches for example. That means that the critical question from our point of view is how we get people engaging with services and how we get them staying with those services once they are engaged—how do we identify the people who are at greatest risk of a suicidal act and get them to receiving those kinds of services? Clinical psychologists are one group, not the only group, who do have the capacity to deliver those kinds of evidence based interventions which are amongst the best bets that we have at the moment.

Senator FURNER—Ms Robinson, if I had my computer in front of me I could access it, but you have the link in your submission for the research of suicide and self-harm in the UK. Could you explain how that differs to our research and development here in Australia?

Ms Robinson—There were two examples that we cited with regard to the things that they are doing in the UK that we are not, to date, doing here. One of them is around a system of monitoring all suicides that occur under psychiatric services and the other one is a system of monitoring people who present to emergency departments with deliberate self-harm. They go about doing those two things in quite different ways.

The project that looks at suicides that occur under psychiatric services was run as a national clinical audit. They look at all suicides that have occurred across the country over the previous year, and they go back and pick up suicides from prior years that have not already been identified. They then link that with psychiatric hospital presentations. They go back and look at the proportion of suicides or the number of people who have died by suicide who are in contact with mental health services. The next thing they do is write to the responsible medical officer for that person and look at some of the clinical antecedents to that suicide. What they have is a long-term funded, comprehensive clinical audit that looks at the clinical features of all suicides that occur in the country.

It is a project that I used to work on so I know it fairly well. It is quite unique, and we could do it much more easily here. What we have here is a system of electronic databases. By doing some quite clever data linkage with various datasets here—certainly in Victoria, Western Australia and New South Wales—you could actually link the datasets from all the suicides in the states and look at what proportion of those people had been under the contact of psychiatric services and look at what proportion had presented with deliberate self-harm or a suicide attempt prior to their death.

CHAIR—We do not know that here?

Ms Robinson—We do not know those things here, not robustly. Given that we know those two groups are the groups at greatest risk of suicide and given that they are targets and identified as high-risk groups under the National Suicide Prevention Strategy, it seems to me to be a no-brainer that we are actually monitoring our progress towards reducing suicides in those groups. That is the data collection system in the UK for looking at suicides. What they also have is a research network that is looking at presentations for deliberate self-harm in emergency departments. That is run through University of Oxford but they have collaborating centres in Bristol, Leeds, Manchester and various other places around the country. That enables them to do exactly the same thing for people who have deliberately self-harmed. We do not do either of those things here.

Senator MOORE—This group has had a longstanding issue around the area of borderline personality disorder, and I am really pleased that your submission actually put some chunks in there. In the second mental health report we actually concentrated on trying to focus on that area because of the lack of focus it had. One of the things we were told by people was the area of self-harm and feelings of isolation, particularly from the system, were felt very greatly by people who had that diagnosis. I was really pleased to see that in there. Is there anything you want to add to that? You mention that in the past they have been excluded from the system so that, if someone has a history of self-harm and is taken through our system at the current stage, there still seems to be a reluctance to take them seriously.

Prof. Allen—Yes, that is an issue. This group of people is extremely difficult to treat but they are not untreatable. That is an important issue because there is a lot of therapeutic nihilism—believing there is no hope and nothing can be done for this group—about this patient. We are learning more and more that when services are provided in the right way and when the right kinds of services are provided that you can do very with this group. Our colleague, Dr Andrew Chanen at Orygen, has an innovative program for treatment of young people with borderline personality disorder, which has published outcome and studies showing that they can be helped and there are effective treatments available.

They are difficult to treat and this means that very often there needs to be specialised services with specialised knowledge and skills, and there needs to be a lot of support for the treating clinicians. As you may be aware this patient group, because of their particular problems, has the capacity to create a lot of chaos in the system amongst the treating clinicians, the police and the emergency department. They often move across all these parts of the system creating chaos and creating a lot of discoordination between the parts of the system that are trying to help. Very often that actually results in exactly the opposite situation. We do need services for this group. They need to be not only offering direct treatment but also offering consultation and support to clinicians who are treating this group. When it comes to suicide, this is a group that is very highly at risk, so they do need quite a lot of attention.

Prof. McGorry—I think that Nick has covered it very well. The only thing to say is that, because of the reaction they provoke—even in people working in the mental health field but certainly in people working in emergency departments—they tend to get excluded or thrown out of care and it is assumed that their suicide attempts are not a serious indicator of suicidal risk. It is quite the opposite: they have got a 15 per cent risk suicide risk. So not taking it seriously is a huge mistake by the system.

Senator MOORE—It is almost as if you are punished if you are not successful—but, if you are successful, you suicide. I was really pleased, because it is one of the few submissions—I think there were three others among the ones that I have read—that even mentioned the group under that title. I think many of the things we have read in other submissions actually do fall into that group but have not been named in that way—and they are not named in the national strategy, which is an issue.

Prof. Allen—If you looked at groups of people who have what we called chronically parasuicidal behaviours—so they are constantly engaging in suicide attempts and self-harm and so forth—not all of them but a very big proportion of them would probably meet the criteria for this particular problem.

Senator MOORE—We had evidence yesterday by people from a health alliance looking at gay, lesbian and transgender issues. I know Orygen has looked at that with young people, from when we visited the area. Can we get some comment about whether that group is actually effectively identified and given the support that I think they need? It would be good to have something on record about whether that is an identified group.

Prof. Allen—You are clearly aware of the issue. The difficulty is in effectively identifying same-sex-attracted youth, because of course they do not talk about it openly often, and so often they suffer in silence or the issues are kept within the family. There is a real challenge. That is a big issue. It is something where we need to have an open conversation as a society about the fact that some young people are same-sex-attracted, that it is a very broad phenomenon that encompasses a lot of different things and a lot of outcomes. Supporting families and communities to know how to respond to that situation in a positive and supportive way is critical. But there are significant challenges to it.

Senator MOORE—Anything from Orygen, Professor McGorry or Ms Robinson?

Prof. McGorry—I would just say that one of the problems that we have with this is that, in the past, psychiatry and the mental health field have sadly had a bad track record in relation to same-sex-attracted people generally. At one stage, it was regarded as a psychiatric disorder. So we do not want to fall into that trap when we are trying to deal with increased risk of other problems in that group. I think it is something that, as Nick was implying, is pretty underdeveloped, and we need to do more work in it.

CHAIR—We had beyondblue here, and they were talking about the programs they are running in schools. They are stepping up those programs. They said they were taking more of a positive approach in terms of, ‘Enjoy life,’ and so on.

Prof. Allen—Is this specifically with respect to same-sex-attracted youth or more generally?

CHAIR—This is my question. They were talking about doing it as a general program, but is there some way of getting a message in there, in the programs that are already running in schools, for example, where they have already got access in terms of putting information in front of children and young people, and getting a message in there as a way of at least getting information to people? I should imagine that quite often young people just are not getting access to this information.

Senator BOYCE—Could I ask another question, which I think will get answered at the same time? The GLBT people yesterday suggested to us that a lot of the mainstream suicide prevention programs were not really suitable for gay, lesbian and transgender people and that they should have their own specifically focused programs. So could you answer both those together?

CHAIR—There are two things. How do we enhance programs that are already running? Secondly is the strategy. I want to build on the strategy one later because I want to ask about some Indigenous focused strategies as well.

Prof. Allen—I think this whole issue—Jo was alluding to it—of universal programs and mental health promotion type inputs sounds superficially attractive, and the suicide prevention field in Australia kind of bought that line, hook, line and sinker, and wasted a lot of money in that respect. It is a good backdrop. It is a bit like in the physical health field, if we tell everyone, ‘You’ve got to have a healthy diet and you’ve got to go for a run every day,’ that is going to improve their physical health but it is not necessarily going to stop them getting a heart attack or developing diabetes, cancer or whatever else. There is still going to be a lot of illness emerging despite those healthy behaviours. So it is all very well to go into schools and tell people to be nice to each other and give all the various health promotion messages. That is fine. But there is no evidence, as Jo was saying, that that reduces suicide risk. It is a belief, not evidence based. So I think Jo was saying, and I totally agree, let us get a lot more targeted, and all the evidence that we do have is about picking the high-risk groups—you have mentioned some already—and working with them. Then not only are you going to be able to reduce the risk but you are going to be able to show that you have reduced it. It is not really either-or, but on the other hand there has been far too much emphasis placed on this universal approach.

CHAIR—The question is then: how do we make sure that we are targeting programs at young people in these high-risk groups?

Ms Robinson—There are probably a couple of things with regard to school based work. I think there is room in the system for universally based wellbeing and education type interventions in school. They will not necessarily show a reduced rate of suicide. There is room for MindMatters and those sorts of things, and that is a good way of promoting resilience and wellbeing and those sorts of things, and there is no reason why they could not encompass things like building self-esteem for people who might be same-sex attracted and those sorts of things. But I do not think suicide prevention can stop there in schools, and up until now that is where it has stopped.

CHAIR—Yes, okay. Point taken.

Ms Robinson—I think that the next step is obviously looking at how we can identify those young people who really are at risk. We know that some young people will seek help in schools—and schools have got very good pastoral care for working with those young people—but we also know that many young people will not seek help. One of the things that I think we again cited in our submission but would argue strongly for are proper systems of early detection for young people who might be at risk, not only of suicide or self-harm but of a range of mental health problems. In the same way that we screen for physical health problems—my daughter gets checked for lice every five minutes at school!—why aren’t we checking our young people to see how they are functioning in terms of their mental wellbeing in a school environment?

We have done a little bit of piloting around that, and it is an intervention that is well accepted in the US. Screening systems are well implemented in secondary schools in the United States. You have got a relatively captive audience, if you like. Just going in and administering simple screening tools to all the high-school students will identify a whole heap of young people who have not already sought help who you can then link in and engage with services. That is really, I think, our best bet for going in and taking a proactive approach to identifying young people who might be at risk of a whole range of things, including suicide.

Senator MOORE—Certainly, the screening tools are useful, but I would expect that some young people, particularly some of the ones who are most in need, would just close down.

Ms Robinson—We have got some experience of doing this, and some people will. Our experience tells us, though, that the majority of the time, when you ask a young person if they are feeling suicidal and they are, they will be honest with you.

Prof. Allen—I want to very strongly support that. I think there is a kind of belief, a myth almost, that that might happen, but actually it is mostly because they have not been asked. And, when you ask them, of course some will hide it but many will not.

Senator MOORE—Because someone has asked.

Prof. Allen—Yes.

Senator BOYCE—They are not concerned about being cool or not being cool is what you are saying.

Prof. Allen—It depends on the context in which it is asked, but certainly, if it is asked in a questionnaire which they are assured is confidential or if it is asked in the context of a one-to-one interview, mostly, people will tell you.

Ms Robinson—We have had some very good experience doing this with a couple of high schools here. In one of them we got over a 90 per cent consent rate from parents and students to actually take part in an evaluation of a universal program with some screening embedded in it. That showed it was pretty acceptable; people did not mind doing it.

The other thing is that we did some simple online screening in a confidential way. Those people who were identified via that as being at risk got to sit down and have a face-to-face interview with one of us. We decided that some of those young people, on the basis of that interview, did not really need ongoing support at the time, although many of them represented to the school counsellor later for help. So it was a quite good exercise in terms of psycho-education and promoting help-seeking. Those we did identify as needing support at that time were linked with the school counsellor with very positive outcomes. So we have some experience in doing this. That is our best bet at picking up young people at risk.

Senator BOYCE—Is that research published?

Ms Robinson—Yes, it is. We published one paper on the back of it and we are about to publish another one.

Senator MOORE—Is that process funded?

Ms Robinson—Partly. We have conducted what we would describe as a pilot study and are desperately seeking funding to do a proper, robust study of fact.

Prof. McGorry—The other thing to mention about that study is Head Smart. Did you mention that name?

Senator MOORE—It is called Head Smart.

Prof. McGorry—Yes. It was not just about lobbing up at the school and handing out questionnaires; it was a process of engaging the school. It was initiated by a role model, Wayne Schwass, the footballer, who would go in and talk about his own experience of depression along with some of our staff to educate the young people first. The screening was conducted in the context of that educational exercise. It was not like a detection system—that was not presented as the main purpose of it—the main purpose was education and raising awareness, but we did the screening in the context of that and it worked very well.

Senator MOORE—I have one more question and it is about evaluation, which is one of the core aspects of the program. It has come out after many questions being asked about what is appropriate evaluation. There is now an expectation of an evaluation process in government funding. I would really like to get some information from both organisations about your understanding of evaluation—how should it be done and is there a common model so that people are evaluating in a similar way? I do not wish to lead people, but we keep throwing the term around and I am not convinced that there is a common understanding of what it means.

Ms Robinson—We did some evaluation a couple of years ago of the projects funded under the National Suicide Prevention Strategy in its previous incarnation, I suppose. What we found was that the quality of evaluations, where they existed, was—

Senator BOYCE—Problematic?

Ms Robinson—Let’s use the word ‘problematic’—

Senator MOORE—Mixed?

Ms Robinson—They were mixed. Maybe we will call them poor. For the most part evaluations of projects were not conducted and, when they were conducted, there was no standardised approach to it. Regarding suicide related outcomes, the interventions were so diffuse from suicide as an outcome that you could not use suicide related behaviours as outcome indicators. A lot of evaluation was process driven evaluation. What you really need is evaluation to be built in from the very beginning. Where evaluations were best done they were done by external bodies. One of the things that we talked about in our submission was a nationally coordinated program of research. If you had a nationally coordinated research network you could draw on the expertise and resources within that network to assist with those sorts of evaluations. What you need is evaluation to be built in from the very beginning. You need a series of time points and outcome indicators—all of those sorts of things—that are readily measurable and standardised across interventions. None of that was done previously.

Prof. Allen—I thoroughly agree with Jo. The thing that you have to remember when dealing with suicide particularly, which is different from, for example, dealing with something like depression, which is relatively common in the mental health area, is that suicide, although it is obviously an extremely serious event, is still a relatively rare event and that, in an epidemiological sense, presents real challenges for studying it. If you take a group of young people, for example, and you want to see whether an intervention has an effect, you are dealing with an outcome that is relatively infrequent. Just from a purely statistical point of view, that makes it difficult to say whether it works. This is why we need a much more coordinated approach, because you are in a big numbers game if you are going to be able to draw strong conclusions. Having a nationally coordinated approach to evaluation of these things is a very important thing, especially in a country with a relatively small population like Australia.

CHAIR—Professor McGorry, you look like you want to say something else.

Prof. McGorry—Nick just reminded me that I did not say at the beginning that, in terms of funding that sort of national capacity to evaluate and measure, in the last couple of months I have been trying to determine how much money is spent on suicide prevention and how much money is spent on the prevention of road deaths. As far as I could work out, there is at least—and this is very conservative—at least 20 times more money was spent on the prevention of road deaths than on suicidal deaths. That means that we are actually saying as a country that, if you die from suicide, your death is a 20th or less as valuable as if you die on the road. That is a totally unacceptable situation from my point of view. We are just not taking it seriously in terms of expenditure on prevention programs and on measurement and evaluation. It is a dog's breakfast. It really has been very poorly done in Australia in the last 10 years or so.

Senator ADAMS—I go to the information that you got from the UK and the way they were able to do their analysis and their data. We have already had the national coronial information people here this morning. You made a statement on road deaths versus suicides. We just cannot seem to get a handle on what constitutes a suicide as far as the information that comes through. I think this is probably the problem. We have had anecdotal evidence that the number of suicides is far greater than what has come out in the data. How did the UK get proper data and information on the number of suicides? Does their coronial system have a different way of reporting?

Ms Robinson—I am trying to remember where the original mortality data came from. We have probably a similar coronial system. What we did at the confidential inquiry, which is where we gathered all that data, is get our core data—and it was some source of mortality data, and off the top of my head I cannot remember where that was—for the previous 12 months, for example. We know there is always a delay in reporting suicide data because of the coronial process. We would have all our deaths recorded for the previous year, for example, and in the following year we would go back and recall all the deaths for that yet again, so we would go back and check whether we missed any deaths because they were still within the coronial process and a verdict had not been reached yet. We did that several times so that we did not miss any deaths that were still stuck in the system.

I think the problem with the coronial system they have had here is that that process did not happen. So, when the ABS were recording the suicide deaths for the previous year, I understand—and there are people with much greater knowledge than I have—they have not gone back and looked for the deaths that were still stuck somewhere in the system and have not reached a verdict.

Senator BOYCE—They are going to do that. They have undertaken to do it twice.

Ms Robinson—That is what they have done now. They will be doing that for the last reporting period—

Senator ADAMS—Central to that is the actual definition of suicide and the way it is reported. There seem to be so many that are not conclusive. How do you count those and where do you go?

Ms Robinson—We looked at all suicides and open verdicts and for the open verdicts we tried to tease out whether it was a suicide. I do not know what the system at the coronial level is here.

Prof. Allen—The ultimate problem with some of these instances is that, unless there is something like a psychological autopsy, you are not going to know. For instance, in single car collisions, accidental shootings, where someone has fallen over the fence—

Senator BILYK—Alcohol induced activity.

Prof. Allen—Exactly. I am not suggesting that that is what necessarily should be done, but I am making the point that, unless you are able to do a psychological autopsy and understand what kind of state the person was in prior to this event which on the surface may not look like a suicide, you are never going to know. So there is an inherent difficulty there. We are probably always going to underestimate.

Senator ADAMS—That is really what I was trying to get at at the start—the fact that if you have not got the data there you cannot produce your evidence, so how are you going to get funded?

CHAIR—One of the issues that came up—and you have mentioned it too—is the number of attempted suicides there are in this country. The Brain and Mind Research Institute said on Monday there could be up to 65,000. To me, that also indicates we have a massive problem in terms of mental health. If you draw the correlation from the number of suicides that can be put down to mental health, 65,000 seems to me to indicate a very big problem.

Prof. McGorry—Yes. Broader youth mental health reports are reporting that the rates are going up. The ABS reported on that a year or two ago. It is an increasing public health problem, as you are implying. Suicide and suicide attempts are the tip of the iceberg, with the huge area of the iceberg below the surface being poor mental health, particularly in young people. We have basically been trying to point that out for the last few years.

Senator BILYK—In the UK, did that information include suicides that were outside the health system?

Prof. McGorry—No.

Ms Robinson—That project was really set up to look at suicides that had occurred under psychiatric services. What they found was that about a quarter of all suicides did occur within psychiatric services. When I was still there we were always looking at how we might be able to start detecting suicides that occurred within recent contact with a primary care practitioner and those sorts of things. That is the obvious next stage, I guess. But at this stage they have not done that.

Senator BOYCE—Ms Robinson, can I start by clarifying something you said. We have had lots of evidence from community organisations, service providers, consumers and carers about treatment in emergency departments and in mental health psychiatric facilities not being good, but you have actually said that the majority of people are not properly assessed and treated. Is that anecdotal or are you able to supply us with statistics to back that up?

Ms Robinson—I cannot give you the statistics offhand, but I can tell you that that is evidence based. There is a piece of work that was conducted by David Owens’ group in Leeds and Nav

Kapur's group in Manchester. They looked at hospital presentations for deliberate self-harm and what they found using that network of data I was talking about earlier that is coordinated through Keith Horton's group in Oxford is that the majority of people who present to emergency departments with deliberate self-harm or a suicide attempt do not receive a psychiatric assessment. When they looked at those people who do get an assessment they found they do better over the long term than those people who do not. So we know that, for the most part, people do not get properly assessed.

Senator BOYCE—That is the British evidence. We have this issue where the stuff we are getting is anecdotal and we have state departments of health, for instance, trying to point out to us that this is from the 'noisy' minority. I was very interested in the percentage you put on it.

Prof. McGorry—We do have some local evidence of that. There is a study that was done at Orygen about three or four years ago now. We called it the Grey Zone Study. Basically, because of the lack of resources in our specialist mental health system, we are forced to turn away 1,200 young people a year from our service who we feel need to come in to us. They have actually made it to the specialist mental health service door and we are able to at least triage and assess them. Our judgment would be that the majority of them, in an ideal world, should come in and receive specialist mental health care. Because of the resource crunch, the lack of resources for public mental health in Australia, we turn away 1,200. We refer them to other places for the most part but 22 per cent of them have had suicidal behaviours. It was not the ideal thing to have to refer those people out to God knows what—the local GP or some counsellor in Footscray. That is the situation.

Our mental health services, whether they are enhanced primary care, the emerging headspace program or the public mental health system, are so scaled down in relation to unmet need that, even when they can get an assessment, people are not getting care. Certainly the situation would be much worse in other states—again, that is anecdotal. The problem is that the mental health system, whether primary or secondary, is not scaled up to respond to the need, and the people, particularly the young people, who need it the most have the worst access across the life span. It is really a massive reform task, which hopefully is on the agenda now as we see health reform and restructuring on the agenda. We have to address it. Jo's point—I think all our points—is that there is a lot we can do to reduce the suicide risk and the suicide toll, but we have to have interventions and we have to build the evidence base in support of it. There can be no more of this fluffy 'Let's all be resilient together' sort of nonsense. That is fine but it is not going to prevent suicide. We have got to act.

Senator BOYCE—It should not be funded under a suicide prevention strategy, in your view?

Prof. McGorry—It is the least definite space thing we are doing in the mental health field.

Ms Robinson—It certainly should not be funded in the absence of interventions that are specifically targeting people at risk.

Prof. Allen—Right. Yes, you are talking about people who have made a suicide attempt. We can also define people as having a strong suicidal ideation—they have strong ideas. It is a no-brainer. This is high-risk group. They are sitting there right in front of us and we do not have the resources to give them treatments that we know work. That is the real challenge. I agree that the universal approaches have their place and they are very good, but if you want value for money you have to deliver the evidence based treatments to the people who are at high risk. We know who they are and we know what to do; we just need to be able to get help to them.

Prof. McGorry—The reason I feel emotional about this is that in the last couple of months I have received absolutely hundreds and hundreds of letters and emails from around Australia and last week sat through a television program where a whole lot of bereaved families were in the audience and told stories of failures to act with regard to people who were clearly in need of serious help and were not able to get it in our system. That is the thing we have to do—we have to build a system.

CHAIR—Likewise we have had lots of stories. We have had not only people presenting written submissions but people presenting to us and telling us stories of their loved ones, their children who have not been able to get access to services and support.

Senator BOYCE—I have been exploring the idea that not all people who suicide have a mental illness. You are saying something which is somewhat different from what has been said to me before, so could you give me a bit more detail about what you believe? For instance, we talked earlier about a person who might commit suicide because their partner left or because they are an old and physically sick person.

Prof. McGorry—That is why I use the term ‘mental ill health’ rather than ‘mental illness’, because mental illness is interpreted as a clear-cut serious mental illness which involves three per cent of the population. It has a very narrow definition. But I think it is quite clear, as Nick was saying, from psychological autopsies that people do not kill themselves when they are in good mental health, but they are in a state of mental ill health at the time they kill themselves. You might say that your partner leaving you is part of life, but your mental health might deteriorate, even temporarily, in the face of that sort of stress. The actual act of suicide can be a very rapid thing, can’t it? If you are temporarily in that state—and this is why it is always hopeful—

Senator BOYCE—To find a solution.

Prof. McGorry—Yes. This is why it is always hopeful, because if you can keep people alive during that period of maximum risk they can live for another 40 years. That is why it is always a terrible tragedy—because it is preventable. When it is has been done, the evidence clearly shows the vast majority—it is hard to think of examples when you would be in good mental health and want to kill yourself. I suppose one example might be if you had a painful terminal illness. That might be one situation. You could be in good mental health but realise the predicament was something you did not want to continue to experience. But an absolutely tiny proportion of the people we see and are aware of actually kill themselves.

Prof. Allen—To extend on that a little bit, one of the critical issues here—it is a bit obtuse, but it is important—is that when we say someone has a mental illness we are drawing a line at a particular level of severity. It is completely arbitrary. If you have five symptoms of major depression that means you do not meet criteria; now that you have six, you do. But all the evidence we have shows that this is not a category but a continuum of problems. A lot of the so-called evidence that people who may attempt or complete suicide do not have mental illnesses are using the strict diagnostic criteria and not looking at whether they are just bubbling under the surface. We know that those people are just as impaired as or just slightly less impaired than the people who are just above them. We have these categories that do not really fit the phenomena that we are dealing with.

Senator BOYCE—I think fixing that is in the too hard basket for this inquiry, though. The other issue that has been raised with us relates to what you, Professor McGorry, were saying about the imbalance between funding for suicide prevention and for other things was the idea of a national road transport authority type organisation aimed at suicide prevention. What is your view on that?

Prof. McGorry—I think it is an excellent idea. You see the power of that structure in relation to the road toll, especially in Victoria.

CHAIR—I want to go back to the issue of the fine line. It may be beyond this committee to decide the fine line, but I do not think you need to define the fine line. If you are providing services and making them readily accessible to people who are suffering trauma so they feel like they have somewhere to go when they feel they are under stress, surely that is the front line when dealing with mental illness and suicide.

Prof. McGorry—That is an excellent point. In a way, the beauty of headspace is that it is a universal system. No-one tries to screen you—’Are you severe enough to come in?’ If you want to go there and you are willing to present as a young person who has problems, you can go talk to someone. Then they can determine whether or not you need help. But it is not a gatekeeping exercise. That is the big difference between the mental and physical health fields. If you go seeking help for a small breast lump or you have chest pain, the doors open up in front of you. But if you currently go with a mental health problem then all sorts of people will be trying to work out where the cut point is—or, as Nick said: ‘Sorry, you’re not severe enough. Sorry, you live in the wrong area. Sorry, you’re the wrong gender.’ The exclusion criteria list is very long.

CHAIR—At the moment we have got to the point where people are starting to think, ‘I need to go for a wellness check or physical check-up.’ Why can we not have the same thing for a mental health check-up?

I want to go to the issue of at-risk groups and specific strategies. We had the Australian Indigenous Psychologists Association talk to us. We got a submission in Brisbane. They and a number of other submitters have suggested that there needs to be a specific strategy for Aboriginal people. I must admit I am quite attracted to the idea because of their specific high-risk issues. Similarly, when I asked the LGBT Health Alliance yesterday they said there probably should be at least part of the strategy to specifically identify high-risk factors. Ms Robinson, you commented about making sure we target the high-risk groups. Do you think we should have separate strategies that deal specifically with the high-risk groups that have been identified? That question is to everybody, but I am picking up on what you said about the high-risk groups.

Prof. Allen—I will say something about it. I think what you need to bear in mind is that the most effective approach is going to be one that combines what we have talked about with a target for those communities. For example, being same-sex attracted or being Indigenous in and of themselves do not put you at risk, but we know that risk is overrepresented in those communities. So, yes, you do need specific strategies that can go into those communities and engage people, but you still need to use the knowledge we have of who the people are who are most at risk so you can deliver services to those. You do not want to target everyone in an Indigenous community or all same-sex attracted youth; we want to use the knowledge we have about who is most at risk within those communities. Of course you will need to adapt those strategies so they are most effective in those communities and those people are most engaged by them.

CHAIR—I hate using the term ‘the contagion issue’—it is a terrible term—but the point that has been made to us on several occasions is that contagion in Aboriginal communities is probably higher than in non-Aboriginal communities. Is that your experience? For example, we were told that, particularly in Aboriginal communities, family and community relationships, particularly in smaller communities because everybody knows everybody, contribute to a much higher risk of contagion than in other communities. Is that something that you are familiar with, and is it an issue that we should also be specifically targeting in Aboriginal communities?

Prof. Allen—I must say I am not familiar with the evidence on that specific issue, but I will say that my knowledge of the so-called contagion issue is that contagion effects are more noticeable in highly stressed environments. One of the contexts where it was first observed was in psychiatric inpatient units, where you have a group of people who are already dealing with quite a lot of difficulty and there is that effect. It is plausible to me that if you have a community, a school or a group within the community where there is a high degree of distress and trauma then it is likely that contagion might be a bigger issue in that context. But I do not know of any specific evidence on that point.

Prof. McGorry—I have heard the same anecdotal information you are referring to, Senator. We do not really have evidence about it, but I would say that it supports what I was trying to say earlier about the role of the media. It is quite a minor role in terms of contagion. I looked at the evidence quite carefully last year before I started to make public comments about this issue, and my opinion is that you can show effects in relation to reporting celebrity suicide, which gets reported anyway, irrespective of any guidelines, and there is some evidence about methods, I suppose, but most of the contagion effect I think, as you imply, comes from local factors—as Professor Allen has also implied.

CHAIR—I am particularly interested in the issue of discharge. I know we have talked about it a bit. We have now been in the ACT, New South Wales, Brisbane and Melbourne, so we have not done my part of the world yet, or Tasmania. We heard evidence that Victoria is not brilliant either, but Victoria seems to be the best of the states so far in managing issues of discharge. You have got some Step Up Step Down facilities being trialled. I would like to hear your comments about Victoria compared to the other states. There was a specific new pilot being trialled in Brisbane that I would like to ask you about as well, in a minute.

Prof. McGorry—At the last Senate inquiry on mental health I think I compared Victoria to the other states in relation to Botswana and Lesotho, and Botswana probably had slightly better mental health services than Lesotho. Even though it is better, it is a big problem for us in Victoria if the governments say they do not need to do anything, out of complacency, because other states are even worse.

CHAIR—The Victorian government has not come, which is disappointing because we have had the New South Wales government and the Queensland government. It is what we have picked up from the other witnesses, and they are not saying it is great but certainly what we are hearing is that it is better than what we have heard about in other states.

Prof. McGorry—I think that is fair comment. Step Up Step Down is definitely a good thing that they are putting in place. Victoria is trying, and Victoria has the best new reform framework. It puts the federal government’s new fourth mental health policy to shame in terms of its approach. It is a 10-year reform framework that was launched last year in Victoria. The government is trying to keep improving. I think it has gone over the complacency. Whether it will invest in it, of course, is another question. But the actual design of the policy reform is quite good. Probably it is a bit more progressive but the scale of unmet need is still massive in this state. They are really baby steps.

CHAIR—When we asked the Queensland department about this they mentioned a trial that is being funded under the strategy. They are putting somebody in the hospitals, for example, in an ED or hospital, to stay in touch when someone is discharged. They are putting in a link person in two divisions of general practice to trial this. I have asked a number of people about this and some have said that it sounds okay. One said they have concerns that the divisions of general practice might not necessarily be the best place to put somebody. Do you know about that pilot?

Prof. McGorry—No, I do not know about that.

CHAIR—What do you think about that type of approach? The person in the hospital is supposed to contact the person in the division of general practice and tell them when a patient is released, if they are in that particular division.

Prof. McGorry—It sounds a bit one step removed to me. As you say, the divisions are variable. My experience with Headspace is that we have dealt with 30 different divisions of general practice around the country—all states and territories. Some are fantastic and some are pretty ordinary. They are one step removed from the clinical coalface. It might be better for it to be linked to the actual practice itself, where the patient is going.

CHAIR—That is if they have a GP.

Prof. McGorry—Yes.

Ms Robinson—We know that the period following discharge from hospital is one of considerable risk, and we also know that there have been a few studies that have looked at maintaining contact with people following discharge from hospital. That has shown a reduced suicide rate. There are studies that came out of the US, and something similar has been done in NSW with people being discharged from emergency departments. The actual idea of maintaining contact and having that direct and close follow-up with somebody is a very good way to go. Whether the divisions of general practice, as these guys said, are—

CHAIR—It is finding the appropriate—

Ms Robinson—That is right. They have maintained contact with somebody. Having a named person that stays in contact so the person has a relatively seamless transition is a good idea. We are about to pilot something in our early psychosis service. We have a buddy system for people who are being discharged from the service. We are piloting it this year. It is a bit of a buddy system for those six months around the period of discharge to see whether that facilitates engagement with the services that people are referred on to. We have not got sufficient numbers to look at suicide related outcomes at this stage, but that is something we would aim to do in the future. Something along those lines is a good idea.

CHAIR—I have one last question. We heard this morning—not in evidence; it was when we were having a cup of tea—about a special magistrates court that specifically dealt with people with mental health issues that also had issues with the law. The person I was talking to was talking about their son, who had got lots of fines. We heard of a young woman in Sydney who had incurred a lot of fines. She had lost her licence because she had not been able to pay the fines. It added to the chaos of her life, and made her life even harder. It seems to me to be quite a good idea. They did not seem to have that in Sydney. They had a bit of trouble dealing with it. Here it gets dealt with through the Magistrates Court. Have you had experience with that and is it something that is a useful thing to help people deal with issues that arise through the criminal justice system?

Prof. McGorry—The whole interface between offending and mental health is a huge one. The parallel with youth is quite striking. The rate of offending starts to take off around puberty, just the same as the rate of onset of mental disorders, and it continues to rise in the early 20s and then drops of after about 25. It is called the age-crime curve. There is tremendous interaction between offending of all kinds and mental health problems. Structures like that are a very good idea. They are just starting. There is a mental health court as well as the magistrates initiative.

They are starting to turn their minds to it in Victoria but we still do not have a forensics mental health service for young people in this state. There is a very good adult forensic mental health service in Victoria but there is nothing for young people, which is when people are at the peak period of risk. So I think new structures in this area would be very good.

If I could just return to your previous point about the primary care link, that is one of the hopeful signs about the proposed national health reform: mental health might be much more closely linked to primary care structures. That would be a very good thing. It would get over a lot of these discharge and referral and cross-referral issues if they were collocated or much more integrated as a health system.

CHAIR—I have taken us way over time, and I am the one who is supposed to be managing time, so thank you very much. I have also been asked, on behalf of the committee, to say congratulations, Professor McGorry, on being Australian of the Year.

Prof. McGorry—Thank you; you are very kind. Hopefully, that will be good for this mental health and suicide prevention field.

CHAIR—Thank you for your submissions and for your time. It is really appreciated. As you can see we are heavily engaged in these issues and we go over time all the time. It is very difficult to stick to time on this issue because we are all so keen to keep talking about it.

Prof. McGorry—Thank you. It is appreciated by us in the field.

[4.21 pm]

LITTLEFIELD, Prof. Lyndel Kay, Executive Director, Australian Psychological Society

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

Prof. Littlefield—Yes.

CHAIR—We have your submission. I would like to invite you to make an opening statement and then we will ask questions. You have seen how it operates when you are sitting down there.

Prof. Littlefield—The Australian Psychological Society contends that there should be more effective utilisation of government funds and resources by putting them into the provision of intensive intervention and support for individuals identified at risk of suicide, and for at least six to 12 months after that identification. That is, the majority of the suicide budget we believe should go to people who are at risk—either before or after a suicide attempt—rather than to the more population-based education prevention programs. So future initiatives should place the emphasis on the provision of resources and staff at the clinical-community interface for high risk individuals.

Programs like Access to Allied Psychological Services—I don’t know whether you have heard of the acronym ATAPS—are very important in this regard, and we believe should be expanded. ATAPS suicide services are delivered by trained psychologists able to do intensive intervention—that is, they operate outside the normal boundaries of suicide service provision—and engage in longer, more intensive and more frequent sessions. These psychologists are linked to GPs, to hospital emergency departments and community services to be called on immediately to assist people who have experienced suicide ideation, plans and self-harm attempts. There must also be follow-up after attempts—both immediately and then spaced out over six to 12 months—and there has to be proactive engagement with people at risk, not only when they seek help but actually outreached to them, because they do not always come to services for help.

Services in the acute and community sectors must be linked in a seamless manner so the suicide client has continuity of care. Resources must be allocated to ensure effective team collaboration and integrated care between services. It is also critical to maintain and support at-risk individuals’ access to stepped care. This is particularly vital following discharge from institutional or hospital care, as this is known to be a particular point of increased risk and places marked stress on team collaboration. The role of collaborative care should be integrated with the role of specific professions who bring their unique and essential skills and effective interventions to suicidal clients. Collaborative aspects of care need support and resourcing.

Programs for people at risk of suicide must include appropriate and comprehensive risk assessment; evidence based, tailored treatment; and follow-up that significantly reduces risk of recurrence of suicidal behaviour, plus ongoing evaluation of the effectiveness of interventions. Personnel in community and emergency services need training in front-line suicide assessment and intervention, and psychologists can play an important role in the education and training of other health professionals and emergency services personnel.

The Australian Psychological Society asks that the Senate strongly endorse the need for training and support of front-line workers and the need for the profession of psychology having an ongoing and extended role in planning, development and delivery of that training. All of the above principles are important to apply to the area of Indigenous health. However, programs of suicide prevention and postvention for Indigenous people and groups should be guided and conducted by trained and, where possible, local Indigenous practitioners.

Special consideration and support must be given to family and friends of those that suicide. The personal and social costs of suicide for many people are never fully resolved and certainly impact on the rest of their lives. Assistance to minimise this impact should be available.

The APS has some concerns regarding the effectiveness of public awareness and education programs. All funding of community education and awareness raising must be accompanied by rigorous and meaningful evaluation of effectiveness and relative benefit. My previous experience on the National Advisory Council on Suicide Prevention was that some of the projects funded were not a good use of money, as they supported a myriad of very small, local programs that were never properly evaluated or written up and kept in a central repository. A clearing house of programs and evidence of their effectiveness should be established. Further consideration should be given to setting up or funding an established organisation that sources, reviews and disseminates research findings in the suicide area. This organisation might also act as a resource for the design of and consultation about the evaluation of funded projects and initiatives.

The APS shares the much-voiced concerns about accuracy of suicide reporting and calls for consistency in the use of terminology across jurisdictions and services. It is acknowledged that the major factors in the limited accuracy of data about suicide rates are inconsistent terminology, lack of standardised criteria, procedural hindrances and social and cultural barriers, and that initiatives to address these where possible are needed. The consequences of under-reporting of suicide are multiple and far reaching, affecting risk identification, preventative support and effective interventions.

Finally, working with suicidal clients is always demanding and stressful and requires not only extensive training and support but the provision of special amounts of practitioner debriefing and support. This should be funded as part of the practitioner’s employment conditions.

Senator MOORE—Welcome back, Professor. It is always good to see you. We have talked before about the need for having some central area so that people can share knowledge. Naturally I have not been able to find the bit in the book while I am talking with you, but what is your understanding of the project that has been funded for CSS? When we talked to the department the other day, they gave evidence that, while it did not meet the repository and central agency aspects that you mentioned, there was a perception that there was—I am just checking with the other senators—an expectation that that was going to keep information on the key programs that were being done.

CHAIR—That is what I understood from our discussion.

Senator MOORE—Professor, you know the area very well. Is that how you see the CSS?

Prof. Littlefield—I am afraid I do not know that program. But we absolutely need a place where all of the funded programs are kept, so that people do not keep on trying to reinvent the wheel, and also the evaluation of them. It is my considerable worry that programs are not evaluated. If you are going to decide on what you are going to be doing in a community, you need a place to look up what works for your particular community before you put it into place. I am sorry—I do not know the particular program. But I totally support the concept.

Senator MOORE—We had not heard of it before either. It came out in the discussion with the department. They have given us a very big submission in which they have listed things, though I cannot find it now. But what about the Griffith research centre project? That is supposed to be a kind of centre of reference—

Prof. Littlefield—Is this Diego De Leo’s?

Senator MOORE—Yes.

Prof. Littlefield—His centre is extremely well respected, particularly for the research that he does. One of my points was on the need to set up some body, or fund an established body, to continue to do research, evaluation and dissemination—because I think the big thing with research institutions is that often their findings are kept there and in the research literature when they are published. We want those findings disseminated into the field in language that is very translatable, so that not only all those in professions but also people who are working in emergency services and other front-line services can readily read what the research is saying. So you need a centre that does that translation as well.

Senator MOORE—And that was the other kind of central funding that was in the program.

Prof. Littlefield—Yes.

Senator MOORE—We hear very good things about Griffith and we were hoping to talk with them but we could not do it—up until now.

Prof. Littlefield—I have had quite a bit of contact with Diego over the years. He was on the suicide prevention council when I was on it and I heard him speak quite often. From all I know, it has got a very good reputation.

Senator MOORE—We met with two of your members who are part of Indigenous psychology and they gave evidence the other day. They talked about the support they had had from the association and how that is a major focus of the work that you are doing in the field. As to the whole area of Aboriginal and Torres Strait Islander issues—and Senator Boyce may have some questions about the fact that they are not the same—that is one of the identified target areas. Is there anything you want to add on that?

Prof. Littlefield—I think it is very important to tailor programs to that community and the way they interact with each other in their family context. It is an extended family and the community is often involved. For instance, often a whole group of them will turn up to appointments with psychologists rather than the individuals we often see in our office. Unfortunately, there are still so few Indigenous—well, psychologists I can speak about: there are 39, I think, in the whole of Australia.

CHAIR—We were told 40.

Prof. Littlefield—I have missed one! It is good that they are all in that association and have actually been located. But when you talk to them there are two things that are interesting. One is that obviously it would be great if those people could treat and work with their own communities but, because there are so few, we need the general community of health workers to get cultural competence and, in particular, Indigenous cultural competence. I have absolute conviction that that should be built into all the training programs of all the health professionals and those who work in emergency and community services so that they do understand how these people think and how they interact and behave. So that is a step down. But each one of us should have training in cultural competence.

CHAIR—Are you saying that a required—I will not say mandatory—part of any training should be cultural competence training?

Prof. Littlefield—I would make it mandatory.

Senator MOORE—As opposed to something that people can choose to do?

Prof. Littlefield—Yes.

CHAIR—We have heard that it is something that you can add on; it is voluntary—an elective. But you say it is a core competency requirement?

Prof. Littlefield—I think it should be and it is now in psychology, but of course we have a workforce that trained many years ago and does not have that competence. In fact, that group of Indigenous psychologists have now written training modules and we are going to financially support them to go around the country and actually deliver it to the various professions. So that will actually be starting quite soon because obviously the already trained workforce will need to go through that sort of professional development again.

Senator BOYCE—Who do you mean by the various professions?

Prof. Littlefield—In mental health I see psychiatry, psychology, general practice, mental health nursing, social work and occupational therapy as being key professions from the health sector. There should be some element of this in police training, ambulance work, youth welfare work and in all of those front-line professions, because they are dealing with Indigenous people, certainly in particular areas of Australia.

CHAIR—When we asked about this yesterday, we heard that the New South Wales Police Force are aiming to have 10 per cent of their officers trained on mental health issues by 2015, which seems to me to be fairly slow going.

Prof. Littlefield—That is conservative.

CHAIR—Yes, very conservative. That is not even cultural competency; that is dealing with the broader issue of mental health.

Prof. Littlefield—If it is that broad, that is extremely slow going.

Senator BOYCE—I was just wanting to talk a little bit more about your comments on universal mental health programs versus suicide prevention programs. Could you tease out for us how you think those should be treated differently and where we are at in terms of achieving that right now?

Prof. Littlefield—The highest risk of someone killing themselves is when they are at the point of having suicidal ideation and plans and often they do go to see a health professional, particularly GPs, in that time period. If those health professionals, particularly GPs, can pick up the signs and ask the right questions, that is where money can most effectively be put to deal with the person in that very high-risk area. Then we get another period if they actually do make an attempt of some sort, even a self-harm attempt, which does not go the full way. The risk period on discharge and on reintegration into the community and follow up for at least six to 12 months is where I think the most effective use of money goes. There is evidence to that. Compared with putting large amounts of money into universal community programs, for which there is some evidence but it is not huge, with limited numbers of dollars we would advocate that the funding go mainly down the high-risk end.

Senator BOYCE—I must admit that some of the universal programs that I imagine you and I are thinking of are extremely popular and well promoted and would appear to be well used. How do we as a committee argue that this is not a useful expenditure of funds?

Prof. Littlefield—It is a very hard thing to argue because you have got to do population based studies. How do you know in the whole community, other than by some sort of statistical means, who is likely to suicide and therefore how many you prevent on a statistical basis? It is very difficult to know but a lot of those programs cost a great deal of money for a fairly small group within the whole population. Whereas, if you pick the people who are at increased risk and really focus in on them, your chances of saving someone are much higher. There is evidence for certain interventions that do work with that high-risk group, so we do have reasonable evidence of the effectiveness of those interventions.

Senator BOYCE—I don't know how much you have heard of the evidence of the previous witnesses. We had Mindframe put to us as an excellent tool for the reporting of suicides but we had a different view put by our witnesses this afternoon. They said—and I am paraphrasing—we need to stop pussyfooting about and get some discussion of suicide happening in a way that encourages people to discuss why someone might commit suicide, and not be quite so precious about the way it is reported.

Prof. Littlefield—I have heard, like you, that Mindframe is very good and sets certain parameters around media reporting and how it should be done. In settings where there are people who are skilled in managing discussions of suicide and can actually monitor the group. In a school, say, where there is a student counsellor or some such and an incident occurs—not even a suicide but a self-harm attempt—you can discuss matters if you have the skills to control how it is discussed and you are aware of people whom it is upsetting and deal with them. I guess I don't have the opinion that Mindframe should be discontinued. I don’t have that opinion at all. I think it is one plank in our management of the suicide issue.

Senator FURNER—Where do we start drawing the line and turning the corner with respect to society’s stigma on people who attempt suicide and people who suffer from mental illness? I had a look at your guidelines associated with suicidal clients, in particular your codes about avoiding discrimination in dealing with clients. What are the guidelines in your profession on the need for that?

Prof. Littlefield—I think stigma and, to some degree, discrimination are being reduced, and that relates to people with mental health problems in general. Look at the impact that the Better Access initiative, the Medicare funding of psychological services, has had. The uptake of that has been enormous. That means that people have been able to go to a GP in the first instance and actually declare that they have a mental health problem. We are now talking well over a million people who have done that. So it is much freer. People feel freer to talk about it at least to their GP, more so in the community, and I think beyondblue has had a big part in that. It has destigmatised it to a fair degree.

I think although suicide is still under that cloud to some level, people are now more able to talk about it, along with mental illness. I think it is an evolving thing. Is that what you were asking? I think there has been a big difference since Better Access came into the picture. If you just look at the uptake, it shows you how people are now much more able not only to access services but to say that they have a mental health problem.

Senator FURNER—In your submission you also refer to the development of protocols with regard to discharge. That is a common theme that has come through a lot of evidence. You go on to talk about an ‘agreed model of care’. Are you suggesting an agreed model of care between the client and the clinician?

Prof. Littlefield—No. Between the services in the first instance. What we have been told by our membership is that, from emergency departments across the hospital system, often there are no protocols, when someone comes into an emergency department having attempted suicide, about how they are discharged. I heard Pat McGorry and his team talking about this too. Immediately linking them in some way with a health professional who will manage them over that crisis period is absolutely critical.

It is the high-risk period and all emergency services, such as emergency departments in hospitals, should have a firm protocol in place. For instance, regarding my reference to ATAPS, what is being attempted under this particular program is for the emergency departments of the hospitals that are involved to have the names of psychologists that they can ring and say, ‘We have someone here that needs assistance.’ They can make the direct link and put them under that person’s care until they can perhaps get back to their regular service, because they might have been previously seeing a psychiatrist or they might have a regular GP. So the person might form a bridge back to that. What is critical is the bridge. You do not just discharge them back into the community with no contact, no assistance and no support. We believe there should be protocols for that.

Senator FURNER—I take it that would have application to clients, whether or not they are admitted?

Prof. Littlefield—Yes, absolutely. Also, with GPs themselves the anecdotal evidence—but we get information back from a lot of members working in these services—is that some GPs are perhaps not trained sufficiently in suicide risk assessment and perhaps sometimes they are almost unwilling to open it up because they do not always know what to do if someone says—

Senator BOYCE—They take too long.

Prof. Littlefield—'I'm actually thinking of this' or 'I've got plans'. In GP training, there should be—if there is not already—training in risk assessment and how you talk to these suicidal clients. Once again, if it has opened up a protocol about what you do then, do not just say, 'I will see you next week.' Get in the psychologist if you have got one from ATAPS or some other worker that is skilled in what to do in that crisis situation. You should have a protocol that does not just let the patient leave the office when they are in that state. I think it applies to multiple services.

Senator ADAMS—Just to follow on with the accident and emergency issue of someone presenting to A&E with a mental health problem and who may be suicidal, we have heard evidence in two other states. With accident and emergency we did not get too many favourable comments, but we have had some about Victoria and the fact that under their triage system they do have a mental health triage person there. What about your psychologists? Are they employed in that respect?

Prof. Littlefield—Not usually. From my understanding it is usually a nurse of some type, but I am not absolutely sure of that.

Senator ADAMS—No psychologist on call or any backup?

Prof. Littlefield—It varies. Sometimes there is a psychologist, sometimes there is a psychiatrist, but it is not common practice.

Senator ADAMS—If your psychologist is not able to handle that particular patient, can they refer them to a psychiatrist? Have they got referral power to do that?

Prof. Littlefield—No, psychologists cannot refer. We have to go back through general practice. So you get that extra step and any step is not a good step because you always lose a certain proportion of patients when you say, 'Go here.' Even in that step they will not all turn up and if they go there just to get a referral to somewhere else, then you have got two steps. The best way is not only direct access from one worker to the other but also facilitated access. So if I were a psychologist working with a suicidal patient who needed to see a psychiatrist, what I would consider to be best practice is to discuss it with the patient, get their agreement and then—with them in the room with you—ring the psychiatrist, make the appointment and, if you needed to, take them there. Otherwise you just lose them through the cracks.

CHAIR—Trouble with the AMA.

Prof. Littlefield—It probably would, but I think that is best practice.

Senator ADAMS—As an association are you having any success in being able to get referral rights, as midwives are at the moment?

Prof. Littlefield—No, we are not.

Senator ADAMS—But you have applied, haven’t you? I mean, you have been trying?

Prof. Littlefield—Well, we have been trying to talk about that, because, with mental health patients, it is a huge issue for people to have to go—first of all it is hard for them to get to any service, it is a big effort. When they get there, wherever it is, they have to tell their story. This is often very painful. In our case, they have to go via a GP, so, if you tell your story to a GP, and it just drains you—depending on the response you get. It could be a good response; it could be a not-so-good response. Then, they say, ‘Well, now you have to go and see a psychologist or a psychiatrist.’ It is really hard for that person to make that bridge—as I said before—and then to tell the story all over again. That is what happens, and it has to happen, because it is only when they get to the specialist mental health services, particularly in the case of suicidal patients, that a really good, comprehensive suicidal risk and mental health assessment can be done. So it would be much better to be able to directly access either a psychologist or a psychiatrist or between those two. It saves money but it also saves the difficulty that the patients have.

Senator ADAMS—I am from a rural area, and it is even worse there, because mental health teams are so overworked that there is a four-week or six-week wait. What happens?

Prof. Littlefield—Imagine that sort of wait if you are suicidal?

Senator ADAMS—I know.

Prof. Littlefield—It is a bad situation, isn’t it.

Senator ADAMS—Yes.

CHAIR—I think we are questioned out. Thank you very much for your submission and your evidence. The committee is fascinated by these issues and is really keen to look into it and make some recommendations that are going to help.

Committee adjourned at 4.52 pm