COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Suicide in Australia

THURSDAY, 25 MARCH 2010

CANBERRA

BY AUTHORITY OF THE SENATE

INTERNET

Hansard transcripts of public hearings are made available on the internet when authorised by the committee.

The internet address is:

http://www.aph.gov.au/hansard

To search the parliamentary database, go to:
http://parlinfo.aph.gov.au

SENATE COMMUNITY AFFAIRS
REFERENCES COMMITTEE
Thursday, 25 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 Humphries, 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

SNOW, Mr James Henry, Private capacity

CHAIR (Senator Siewert)—The committee is continuing its inquiry into suicide in Australia. I welcome Mr Snow, an ex-MP. Do you have any comments to make on the capacity in which you appear?

Mr Snow—I appear here as the father of a girl who committed suicide, as a member of HOME in Queanbeyan, as an ex-pharmacist to some extent and as an ex-community worker of Queanbeyan City Council.

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

Mr Snow—Yes.

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

Mr Snow—I thought I would briefly touch on my experience with my daughter and then mention some deficiencies as I see them in the provision of assistance to the mentally ill in particular.

From 14 Natasha developed schizophrenia. Both paranoia and delusions began to develop from that age. When she was about 30 she began to start to lose the delusions, mainly because of her medication, which was risperidone. She really missed those delusions—the friends, in other words, that she had. Suddenly she was without these friends talking to her. Sometimes they were awful and sometimes they were very pleasant friends. Suddenly they went, and she was so lonely as a result. Up until then she wanted to live on her own in Mawson in the ACT.

She was so completely lonely that she became extremely distressed. We did not understand at that time that it was probably because the medication was really working. I stayed with her for a couple of nights in her unit. We made an appointment for her with her caseworker and a psychiatrist at Canberra Hospital. What she usually did when she was in trouble was go to Calvary and say, ‘I need to come in for a few days.’ They would help her sort things out and then she would leave after a few days and she was usually quite happy. Calvary had no beds, so we made an appointment for her to see a psychiatrist at Canberra Hospital. She went with her caseworker there.

She and I agreed in the morning that I would return at five o’clock and be with her again that evening. We would have an evening meal, and I would be with her. I returned at 5 pm and she was not there. At about 5.30 got a telephone call telling me that she had taken her life. She had jumped from a building in Canberra city. Somehow she had got into a friend’s place at Currong Flats and got out onto the balcony and jumped over. She died. I think she jumped from the seventh floor.

She had an interview with the psychiatrist and he had given her diazepam—Valium is one brand of diazepam. I got all her records later and I could not find any record of her being given diazepam. As I mentioned in my submission, there is a very strong warning about giving diazepam to a person who has not been given it before, particularly mentally ill patients and people with psychoses.

The psychiatrist said—and I am not completely critical of the psychiatrist—'Take this diazepam. I will give another one to the caseworker and he can see you at five o'clock when you get home.' She took it. In my opinion, the diazepam probably enabled her to do something that she often thought of doing, which was to take her life. It made it more acceptable to her to take her life. She wrote a note to all of us saying that she loved us all, it was not anything to do with us and that sort of thing. It was a short note. And she jumped from the building.

The deficiencies I see were, first of all, a lack of coordination between her psychiatrist and the hospital psychiatrist. I think the hospital psychiatrist had trouble getting on to her personal psychiatrist. It was interesting that when the coroner had his hearing that her personal psychiatrist said: 'If Natasha wants to go into hospital, Natasha needs to go into hospital.' It is a pity that that information was not available to the hospital psychiatrist. In other words, she had complete faith in Natasha's ability to determine that she really needed that sort of help. So there was not that communication, which was a problem.

The other problem I saw was that there is nothing between a mental hospital and refuges, Richmond Fellowship houses and things like that in this region. Refuges of course are inappropriate for those patients. My wife was heavily involved in women's refuges for some time and quite often they would get mentally ill people. The refuges are really not suitable for those people. It is particularly unsuitable for the other residents in those women's refuges. That is one real problem.

She had tried the Richmond Fellowship and felt very ostracised, even if she was not, by the three or four people. When she went into hospital she could walk around and find someone she could relate to. With 20-odd people there things went okay. I see a real need for something that is less difficult for newcomers than those houses and something that is good for short-stayers, who may not want to stay in a house and who want to go back on their own again.

I suggest here what we have done in Queanbeyan: having a hostel for up to 20 places, which is being opened on 1 July probably. There is a flexibility there that is in hospitals, where she can walk around and make friends. There is supervision and there are professional staff available. It is far less expensive than hospitals. They are far less likely to say, 'Sorry, no beds. Sorry, we can't take this girl.' Also you can take part of the Centrelink income, for instance, as do some aged persons services. Not that I am saying that hostels should be modelled on aged-care hostels, but you can take some of their benefits from people. I think what we have to do is get away from that idea that was absolutely relevant when we got rid of mental hospitals, or lunatic asylums as they used to be called, and replace them with community services which either did not work or were not properly provided for.

The next point I want to make is that patients often stop taking their drugs. They might say that they put on weight. In Natasha's case she was getting distinctions in university and suddenly she could not get them when she was on medication, so she had a choice between not taking medication or taking it and not being able to study. Other people talk about weight problems. Others say, ‘I think I’m right now, I can go without,’ or ‘I should be strong and do without these drugs.’ So there is a lot of noncompliance in the taking of these drugs.

Something I did not mention in the report and I think is particularly relevant at the moment is the problem with the federal system. Natasha was continually moving between Queanbeyan living with us and Canberra when she wanted to be on her own, maybe having a unit or something like that. Queanbeyan is closer to, say, Civic than a lot of suburbs of Canberra. But as soon as she went across she would have to change her caseworker and she would get sick of that. It was very annoying. The caseworker would have to send a report across, she would get a different caseworker, one she had not had before. All this moving around which she felt she had to have did not really work for her. When I was a member there was a patient in Delegate and the doctor said she needed to come to either Canberra or Calvary to psychiatric wards. I phoned Canberra Hospital with the cooperation of doctor and Canberra Hospital said, ‘Look, we’ve only got one bed left for this weekend and we’re going to keep that for people in Canberra.’ That was not true. I rang the head of the Canberra health service on the Monday that he said, ‘That’s not true. They are supposed to take people from the region. Canberra is a regional hospital.’ This is what happens when you have got the border problem and people somewhere else and it might be a localised decision within the hospital policy development maybe by the nurses themselves over a weekend. They did not take her, and that woman was in a very bad state. The same could happen between Tweed and Coolangatta and Kaniva and Bordertown, and one could name other places, Albury and Wodonga, places like that.

In conclusion, I would like to say that I think that the secret is probably hostels and Commonwealth control would help people a lot more. Drug compliance of course is an ongoing problem, but hostels would even help there if there is some supervision. Coordination and privacy is probably a problem for professionals and government and patients and carers to work out how you deal with those issues. We were not able to talk to the psychiatrists. Once Natasha was in her 20s at least, they would not give any information to us. We could talk to them but not listen to them.

The other point is recovery. My view is that hostels are necessary where houses do not work and where restraint is not needed. And they are far less expensive than hospital beds. Hospital beds are unnecessary for a lot of these people. Another point is consistency in counselling, and that is where the state borders and the different rules often make difficulties but also confusion.

CHAIR—Thank you, Mr Snow. I know it is always difficult to talk about your personal experience but it is obviously something you are turning into trying to make change, which is extraordinarily valuable. I am interested in the concept of the hostel. In your submission you said you are on the board of HOME in Queanbeyan.

Mr Snow—I am a member.

CHAIR—When this committee did a previous round of inquiries on mental health there was a lot of discussion about community focus and safe places. Many people were saying that they wanted safe places. There seems to be an ongoing debate in some areas about size. There is a concern by some people that what we are doing is re-establishing institutions. I think it is really important that you have been involved in this process and you understand the worth, and it would be nice to have something on record about your position and the people who are working on the hostel arrangement in Queanbeyan, which sounds so positive and community focused. It would be good to get something on the record about why you believe this kind of midsize—I got the impression it was about 20—

Mr Snow—Yes.

CHAIR—How that fits into what continues to be a debate about, in terms of establishing a safe place, is 20 a small institution? I am sure you have heard about the debate. I would like to get something on record from you about your position.

Mr Snow—I was a foundation member of HOME in Queanbeyan and we found that HOME in Queanbeyan had to be viable, of course. I was a community worker before I became a member of parliament and in between pharmacy a community worker at Queanbeyan Council, a foundation community worker. There was an occasion when my successor found that there were of 21 people who were sleeping out under bridges, on seats around parks, in the middle of winter in Queanbeyan. You can imagine what that is like. Sometimes there are up to 50 people homeless around Queanbeyan and most of them are mentally ill. So HOME in Queanbeyan was partly an effort to deal with that. It is a bit like frail aged hostels in terms of viability. I reiterate that it is nothing like it in the running; you need to have a different system set up. To be viable you need about 20 people. That viability is very important.

When I was with the council I was acquainted with Kenmore Hospital in Goulburn and people going there and I was acquainted with the effects of the Richmond report when people were asked to leave those places. I remember one chap constantly coming in to see me when I was a member about whom it was assumed that he would be there for life. All his tools were taken off him and sold and his house was resumed by the council and sold, and then he was released in four years time. He was Hungarian, as I recall; I am not completely sure. He had no tools of trade, he had no home to go to because it had been sold. No-one seemed to know what had happened with the money. It was supposed to be taken for back rates. No-one would take responsibility. That man became quite a wreck and a real problem. I will not go into his story. So, yes, they were released, but there was nothing in the community to replace it.

The problem is that departments—or in the New South Wales department, which is one of the oldest departments in Australia, the Department of Community Services—cannot get out of that huge problem of the ‘lunatic asylum’ that developed. But we do not have to do that anymore. We do not do what we once did with nursing homes in the old days, yet people still dread nursing homes because they think they are like they used to be, and they are not always—they mostly are not. We can be the same with these hostels for the mentally ill—not the severely mentally ill who need restraint but people who do not. I think that they have got to make that jump now, and I have to congratulate the New South Wales department on not only coming to terms with what we are doing in Queanbeyan but also being prepared to be on the Tenancy Review Committee. So there is quite a change happening there, as I see it, and it is at least something worth trying. I believe that there is something happening in Melbourne too but I cannot tell you anything about that.

Senator MOORE—Has that been a recent change, Mr Snow? When we were doing the mental health inquiry a few years ago there seemed to be great tension and the state governments were very fearful of recreating what they saw as institutions. I actually support your position. I have always seen that there is a need for a whole range of options—one size will never fit all. In your submission you said that HOME in Queanbeyan has got federal, state and local support—

Mr Snow—Yes.

Senator MOORE—so you have been able to achieve funding for this particular program.

Mr Snow—Yes. I think we have because—and I should admit it—it is a marginal seat and some of us are well experienced in dealing with marginal seats.

Senator MOORE—Senator Humphries is fully aware of all that and I am sure that he will be asking questions.

Mr Snow—I pay tribute to the former member, Mr Gary Nairn, and the current member, Dr Mike Kelly, for both agreeing to provide good funds to HOME in Queanbeyan. New South Wales has also provided funds well away from an election—

Senator MOORE—Sure.

Mr Snow—and that is to be accepted too. I think that in each case it was done because each of the three members, Gary Nairn, Mike Kelly and Steve Whan, the state member, have been convinced by the community support that has been received. The local clergy, local consumers, accountants, solicitors—people who are heavily involved in the community—have been able to get very strong community support right across the board. It has been quite tremendous and it really has worked. I think that those three members have seen that strong community support and a case has been put which has been accepted by government.

Senator MOORE—Is it long-term funding, Mr Snow?

Mr Snow—The state probably will be funding it. We have been able to get funding to the extent that we can provide some support, but there has to be a lot of local support—

Senator MOORE—Absolutely.

Mr Snow—Some of that funding has been used to create further funds coming but, I am afraid, there has to be ongoing community support.

Senator MOORE—Yes, in terms of the future, thank you for that. We will follow up on how it is going. I think that it is a really positive option.

Mr Snow—Thank you.

Senator HUMPHRIES—Thank you for that evidence, Jim. The comments to make about hostels are very well made and, like Senator Moore, I completely agree that something which is in the nature of a facility or a home or a quasi institution is required for people in certain circumstances. The crucial difference between that and a place of compulsory detention, I think, is the critical difference here. Your comments about problems of the cross-border service delivery are very good. I think I recall you were a member of the Shed a Tier organisation—

Mr Snow—Yes.

Senator HUMPHRIES—which was in favour of reducing the barriers that form between states—and states and territories, in this case. You have illustrated that point very well in this instance. In the present model is there any recommendation you would make to us about how you deal with those issues of people moving across borders? I suppose there have to be boundaries somewhere in terms of the delivery of services. You have to have some organisation responsible for providing for people in certain areas. Is there a practical way of being able to somehow make those borders less relevant even if you do have to have borders?

Mr Snow—I think there is using a model that is possibly a bit unfortunate at the moment—the police. We have had a very bad accident where the New South Wales Police were chasing people across the border. Nevertheless, I think it has been great for both areas that police in each area are able to work in the other areas and cross borders and continue to take action.

If caseworkers in some way were able to keep the same client wherever they are, it would be very good in my view. I do not see why that cannot be worked out. They have a lot of different rules to comply with and it does create difficulties. For instance, with the police there is a difference of view on both sides about what should have been done and it could have created difficulties. That could happen with the mentally ill. So, unless we shed a tier, we will continue to shed tears over those sorts of problems with the state borders.

Senator HUMPHRIES—Did Natasha ever have any interaction with the Personal Helpers and Mentors program? PHaMs was run by FaHCSIA and was set up in 2003.

Mr Snow—No, she would not have because she took her life—

Senator HUMPHRIES—Sorry, you are absolutely right; of course she did not.

Mr Snow—It is all right. She took her life on 12 September 2003. The ACT were quite good. They got her working in a cafe. She was doing waiting work. She did a photography course, which she loved. So there were some quite good services happening and good things happening when she was feeling okay and able to do them. But when she became quite paranoid and delusional she would drop out, the same as she did from university.

Senator HUMPHRIES—You mention in your submission that one of the factors that led to her tragic loss was a lack of communication by professionals to family, apparently due to privacy considerations. Did you have particular instances where you wanted information about Natasha's condition, her whereabouts or something else about her that you felt ought to have been provided to you or your family notwithstanding the privacy considerations?

Mr Snow—Maybe I should have known but did not realise that the risperidone was actually working. It would have been great if we could have known. We later found that her personal psychiatrist was aware that the tablets were working, that she was losing the voices. It was not clear to me that her loneliness meant that she needed people around her and someone with her nearly all of the time. Previously she did not want people around. Reconciling those two situations did not come to us until after her death.

We could have been told that this was going to happen to Natasha. We were the only people who were constantly involved with her—she stopped talking to me for about 1½ years because she thought I was a serial killer. While that was very hurtful at the time, I can understand that happening. But, when she suddenly lost the voices that were probably telling her these things, she asked me if I could help her find a doctor and do something about it, but I was still unaware that the tablets were actually working. I do not think she wanted me to talk to her psychiatrist; I am sure she did not. I did not know how to resolve the problem, because I think privacy is extremely important in a lot of cases. We could not do much about it, but I think it was a huge problem.

Senator HUMPHRIES—There is no solution to that problem if she was not prepared to give her consent. But, if she had been prepared to give her consent, would you have expected the psychiatrist to have shared that information with you?

Mr Snow—If she had given her consent, I would have. It is a pity that the two psychiatrists had not shared the information either.

CHAIR—Between the two of them?

Mr Snow—Yes.

CHAIR—The fact that the medication was working?

Mr Snow—That is right, but I realise that the contact may have been impossible at that time. But, if that is the case, you do not give Valium and say, ‘Go away and then come back.’ As I have quoted in there, MIMS said that there should be constant supervision.

Senator HUMPHRIES—Did Natasha access organisations like Lifeline at any stage?

Mr Snow—She probably did. She found hospital extremely valuable—Calvary and Canberra—where she would talk to the psychiatric nurses. She found them more helpful. The records that I have are all about what she was saying to them. It indicated a lot of personal contact and empathy from the psychiatric nursing staff.

CHAIR—I want to follow up on the issue of medication, which has come up a number of times. I also want to follow up on the issue of privacy. Maybe I will go there first. It has also come up a number of times. Everybody understands the issues in terms of the need for privacy and respecting it but also a number of times issues have been raised such as: ‘Well, if I’d known, I could have put this intervention in place.’ I am wondering in certain circumstances whether, without divulging personal patient information, there is a process where people can easily access information on particular medications so they can understand what the potential success rate is like and what the side effects are, so that carers and parents can at least get information without potentially violating people’s privacy. How can we ensure that carers are better informed without going behind people’s backs and without breaching privacy rules?

Mr Snow—I think that, if anyone could have realised that risperidone was actually working, I should have. One can go on the internet and find these things out. One of the problems with me was that risperidone had been tried by her and rejected by her previously. This time it was tried far more consistently and she kept on it.

CHAIR—Rejected by her in terms of not wanting to take it or in terms of it not working at the time?

Mr Snow—Not wanting to take it. She told me personally that she had the choice of either taking it and not being able to study or not taking it and being able to study. She decided she wanted to study. She also had weight problems with some of her medication. What I probably should have done is to have read it all up and to think, ‘It could now be working,’ but I did not even know.

CHAIR—That was my question: did you know? That is the point: if you do not know someone is back on their medication, how would you have known?

Mr Snow—That is right—I did not know she was back on it.

CHAIR—She did not want you to know any of the medications she was on either?

Mr Snow—No. She was, as I said, paranoid, and she did not want us talking to the psychiatrist. I was not even allowed to tell her sisters, and she did not want me to tell her mother, about the problems she was having with voices. She would tell me about her voices but no-one else. Also, she did not want anyone else in the family to know about some of the jobs that she went for. I had been a confidant up until that year and a half and then I was not. Her family told me she had not told them about all that, and she had told me not to tell them. Paranoia had a lot to do with the problem.

CHAIR—It is an extremely difficult issue. As I said, it has come up a number of times, and there is no answer.

Mr Snow—I do not know what can be done about it. You hear about civil liberties versus the need to know time and again.

Senator MOORE—We have heard them all, Mr Snow. What we have not heard is those two arguments together. I am increasingly of the view that it would be nice to get people with both views together, but it is an extraordinarily confronting issue. It bedevils me—I just do not know what to do about it.

Mr Snow—No.

CHAIR—I want to go back the issue of the use of diazepam and the whole issue around her not being supervised when she left the Canberra Hospital psychiatrist. Again, those issues have come up a number of times—leaving either the emergency department or some other place where the person was in care without having either a crisis plan or a process for implementing a care plan, if they have one, and many people do not have a care plan. Was it usual that she would be released without having whomever she had seen ensure that she was going into a supervised situation, particularly if she had had a change of medication, or being put in direct contact with somebody else as she was released?

Mr Snow—No. I had not known of that happening to her before. In fact, she had admitted herself to Calvary Hospital previously, and they had accepted her. They did kick her out one time—expelled her from the hospital. Someone had brought in alcohol and she had gone outside with them to sit under the trees, and they got a bit drunk and got into trouble over that. She was okay after that; she contacted me and things worked out. At other times she came out better than when she went in. I can understand the pressure in a hospital, when they might not have beds, but they say they did have beds. They said in the report to the coroner that they could have made a bed available but that a bed was not warranted in her case. To me, yes, there was a problem in giving her diazepam. It definitely should not have been given unless, for instance, the psychiatrist had said to the case worker, ‘You have to be with her right until she returns when she is due to see her father at five o’clock. You need to be with her because she has not had those medications before.’ It might not even be known whether she had had them before. It is a huge problem, and I would add it to the number of hospital deaths from poor medication, which is quite high. It is a big problem that any prescriber can have—prescribing something at the moment due to the pressures of time.

CHAIR—How to deal with the short-term issue while somebody is being treated with a long-term care plan or with long-term medication?

Mr Snow—Yes.

CHAIR—You have raised here and in your submission the issue of coordination between her psychiatrist and the hospital psychiatrist. It is an issue that has come up time and again—the lack of coordination across services, not just specific health services but also allied health services and housing, for example. We have touched on the issue around hostels and it sounds like we are in unanimous agreement over that issue. People have also brought it up in Victoria, where they have been calling them Step Up/Step Down facilities.

Mr Snow—I know that in the ACT there were problems between ACT Housing and Mental Health. My daughter was a resident in Lyneham, in ACT Housing, at one stage. She left because there was a very strong smell, which smelled to her like meat going off, in the apartment next door. I do not know whether she reported it but someone did. They found a dead man there. He had been mentally ill. There is a tendency for each of the departments—Mental Health, for example—to say to Housing, ‘That is your problem now,’ and vice versa. So it is not only across state borders but it is also between different agencies, as you said.

CHAIR—I think we have struck it in every state we have been to so far—that lack of coordination across agencies. Victoria seems to be handling it. There are still issues, but Victoria seems to be an example of where it is happening best. It has not been solved, but it is better there. They have a special Magistrates Court, for example, to deal with issues relating to mental illness and they have a number of other support services that seem to be heading in the right direction.

Mr Snow—I am a patron of Winnunga Nimmityjah, an Aboriginal medical service based in Canberra which tries to service the region, as Senator Humphries knows. It has had problems.

They kept their mental health person at Winnunga, but then decided it might be better to transfer him to Mental Health. He went over to Mental Health but they found it worse and he is now back at Winnunga. So there is another problem, between agencies, of how best to deal with Aborigines who have mental health problems.

CHAIR—I notice we have run out of time. We always tend to be running out of time in this inquiry—we could keep talking for a long time with each witness. We really appreciate you coming and sharing your story. We know it is stressful. We appreciate it. I think you will find that we will come up with a unanimous report—we usually do on this committee—on making some recommendations for some ways forward.

Mr Snow—Thank you very much.

[9.44 am]

LEWIS, Associate Professor Ione Ruth, Vice-President, Psychotherapy and Counselling Federation of Australia

CHAIR—Welcome. Do you have any information to add about the capacity in which you appear?

Prof. Lewis—I am a member of the PACFA Research Committee as well.

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

Prof. Lewis—Yes.

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

Prof. Lewis—Thank you. PACFA is a national federation of 38 counselling and psychotherapy member associations. It has established, through a process of consensus across the diversity of member associations, national standards for training counsellors and psychotherapists in ethics. We have funded a chair of psychotherapy and counselling at La Trobe University for the last three or four years. We have made a lot of submissions to Senate inquiries over the time that we have been established. We do have an interest in suicide, both prevention and postvention, because so many of the practitioners on our national register, and those who are members of member associations, are involved with the high-prevalence disorders like depression and anxiety and some specialise in the low-prevalence disorders, like eating disorders and psychotic illnesses. The other thing to note about counsellors and psychotherapists is that they are spread across urban, metropolitan, regional, rural and remote areas. There is a very wide spread, so that is a real asset to mental health interventions.

The submission that we are making about suicide in particular is that there is a need for national standards for suicide prevention and for risk assessment training, especially given that for an issue like severe depression it is very difficult to accurately identify whether or not people will complete or attempt suicide. The risk assessment which is very brief or is carried out at the bedside before release is not going to be very accurate. There is a real need to have follow-up services, and all states and territories should be providing those.

The LIFE Framework strongly recommends that there be training on suicide prevention but for a very limited range of occupations. It includes journalism, which is very important for appropriate media reporting, but we are really strongly advocating that issues around risk assessment and suicide prevention should be incorporated into a much wider range of university training. We have identified a lot of issues through research and through our practitioner feedback around first responders to suicidal deaths. Again, national standards would assist in ensuring that people receive a consistent response, that they are responded to sensitively and that there is appropriate follow-up for postvention services, which clearly is not occurring at the present time. Presently there is a seriously at-risk group. There was a South Australian report by Clark and Wilson, from the University of Adelaide, that showed how much the follow-up varied even in one state. It perhaps depends on how sensitive the police are and whether the funeral directors give information. There is not an automatic response. There is also a wide variation in how coroners courts follow up with families across states.

We are recommending a dedicated line for suicide prevention for carers and families, who are often the ones who pick up that there is a critical issue and do not know where to turn, and for people suffering from depression or at risk of suicide. It is really clear that the people who are most financially disadvantaged will not be able to access services like Lifeline without a really high charge on their mobiles. By definition, people who are mentally ill do not have a lot of the indicators of social inclusion like housing and a landline, so it is actually very expensive for them to call for help.

In presenting for the submission today, I was wondering about being on this committee and hearing stories from across Australia and stories like Mr Jim Snow’s and just how important clinical supervision and debriefing are for people exposed to suicide—hearing how things have gone wrong and the very high distress of people who are suicidal. Some professions offer those services but community services tend to not have such structured supervision. It ensures quality, it ensures that people do not burn out and it holds professionals accountable for what they are doing, so we think that is very important.

There is a need for in-patient facilities for young people and adolescents. I was listening to the hostel discussion. For example, in New South Wales, the number of critical care beds is very low and you would need to book those in advance, which is a ridiculous situation. Campbelltown has very few psychiatrists in private practice, for instance. You would have more psychiatrists in one practice in Annandale than in the whole of Campbelltown in the south-west of Sydney. Then there are only 10 beds available for adolescents. Some of the practitioners involved in working with adolescents noted that families then have to take responsibility for keeping their young person alive and dealing with all of their issues and grief and trauma at the same time. That seems very unfair. We would not require the family of a young person with leukaemia to provide all that care but we do for mental illness.

Another thing that I want to say about the training for workers is how much research there is on the stigmatising attitudes of emergency departments to people presenting with suicide attempts. That needs to be a part. There is a culture—and I have worked as a social worker in emergency departments and in intensive care units and experienced this myself—that they are taking up resources when health systems are under pressure. These people are taking up resources rather than being seen as suffering from a genuine illness that the health service is required to address. That is a problem.

We are also recognising the role of parents and carers but there is discussion around confidentiality and privacy versus information. If the national mental health policy of No Wrong Door is going to be implemented, it needs to be through national standards about services responding to carers and defining that very broadly, not just as the next of kin on the hospital record. There is a lot you can do with families—providing information around managing a crisis and recognising when you should be bringing your young person back to accident and emergency—without violating confidentiality. A great deal of intervention can occur to inform and skill up carers. Again, there would be an additional workload, which is an issue, but it is very important that we look at how mental health services, community services and hospitals could be doing that.

There is not enough research on suicide prevention or postvention in Australia. Overseas, much more work is done on, for example, the rights of people bereaved by suicide. I believe that Finland has done some work in that area. I think that is very important—along the lines of the Charter of Victims Rights in New South Wales, for example. I think there is some work that we need to do there. There has been some work at UNE—small qualitative studies looking at people bereaved by suicide and their needs. These studies show that these people are not one group. People respond very differently: there is a very resilient group, and there is a group that lives in tragedy for a long time. You need to really differentiate your services. A lot of the resources available for people bereaved by suicide are written within a deficit model and are not strengths based. They give the wrong message to people bereaved by suicide—for example, the one in New South Wales that people will not regain meaning for five to seven years. What kind of message of hope is that? Five to seven years is a long time to live without meaning. So, I think a lot of work needs to be done, and this inquiry is a great opportunity to provide some national frameworks.

Senator MOORE—Is PACFA engaged in any of the government working groups or advisory groups—those kinds of structures that we all seem to love so well?

Prof. Lewis—We provided input into the Fourth National Mental Health Plan consultations. We were invited to participate, with the other professional groups, so we certainly provided input into that. We have participated in the mental illness workforce planning that is going on, and we are going to make a submission on that. We participate very strongly. We are a member of the Mental Health Council of Australia. We are a member of the Butterfly Foundation, which looks at eating disorders. We participate in as many forums as possible and provide input.

Senator MOORE—That is a significant move forward, isn’t it, in terms of the authority of the group?

Prof. Lewis—Yes, I think that is true.

Senator MOORE—You talked a lot about national standards. From your perspective, how would that work? Who would do national standards, where would they lie and who would make sure they were operating? It is one of those terms that flow off the agenda, but what does it mean?

Prof. Lewis—The Fourth National Mental Health Plan is an attempt to set standards, but it does not really have teeth, because it does not make anybody accountable. Perhaps the Rudd proposal to have health operated out of a federal model rather than a state and territory model would be a way to ensure accountability. So, that is a difficult question. I would say that COAG would be the forum to set it up. It is really a process of building consensus across states and territories about what is needed. Coroners’ courts often seem to operate very autonomously. That is necessary in some ways so that they can give strong feedback in cases where things have gone wrong in state health systems, but I think a lot could happen if we coordinated services. Dr Colin Benjamin, our CEO, just reminded me that we have a national credentialing system in place called ARCAP to ensure standards for our counsellors and psychotherapists, but I think your question was a bigger one.

Senator MOORE—Yes. Through your submission and your evidence you talked about the need for national standards across a whole range of activities to do with people who are engaged with people in difficulty. I agree that there should be some sort of process to ensure that people have set training and feedback. Certainly your submission was very big on providing support for those people who are working in various areas. I am just struggling as to where national standards would be. I suppose that the LIFE program that has come out could be one area where people could be looking at that.

Prof. Lewis—Again, it needs to be updated. This has not been updated for some time now. There is still a current review of youth suicide from the NHMRC that is very out of date and that is not really very good quality because it did not evaluate the quality of studies. It just reported on the findings of studies as though they were all the same. So there is a real need to update this framework. I think it is a very good framework.

Senator MOORE—What is the date of that one?

Prof. Lewis—I think it is 2001.

Senator MOORE—I should know, but it is consistently mentioned. The department nominates that plan as the basis of the whole suicide—

Prof. Lewis—It is actually 2000 so it is 10 years out of date.

Senator MOORE—That is quite a long time. We should check with the department about evaluation.

Prof. Lewis—Certainly the NHMRC literature review on youth suicide needs to be redone in a way that evaluates the rigour of the studies and the level of evidence.

Senator MOORE—We had the Australian Institute of Family Studies yesterday. They are deeply involved in that evaluation of the youth suicide prevention program that was a couple of years ago.

Prof. Lewis—Yes.

Senator MOORE—And there are no paper copies available so you have to get it from the system. It always interests me when that happens. In terms of the kinds of standards—because I think that was the core part of your submission—it would be the kinds of skill levels and personal coping mechanisms and institutional supports that are available to people. Are they the kinds of areas that you are focusing on?

Prof. Lewis—Yes, and I think best practice standards for services which should include families and carers in care plans, for instance.

Senator MOORE—Sure. SANE Australia was talking yesterday particularly about the crisis plan and the care plan and that they are not the same thing. People sometimes do not realise that, if you are a person in crisis, quite a focus of the plan goes from there. You would say that there should be national standards for how those plans are developed?

Prof. Lewis—And also for joining up the dots across the outpatient and in-patient services. In our submission we wrote about practitioners who had to use detective work to discover where long-term clients were and who were not informed on discharge, yet they were really the de facto follow-up service. If you do not know about an admission, and you do not know about a discharge then that is a very poor level of service.

CHAIR—Yesterday SANE Australia talked about having a template they are developing which you could even give to an ED, for example. If it were at least just a crisis plan that was in place; even if the phone numbers were already there, they could go and fill in some of the detail and they would at least have something when they left.

Senator MOORE—At that point of communication. Everyone says that no-one should be released from any facility into the ether.

Prof. Lewis—No.

Senator MOORE—If you are leaving a hospital or an emergency area, there should be something documented that you are going into someone’s care. But how that is actually done varies enormously.

Prof. Lewis—It does and sometimes people are released back home just on their own, which is very inadequate.

CHAIR—We have had a large number of examples of that happening.

Senator MOORE—The statistics are particularly bad in terms of people who have done studies. I am never sure how you get this information, but people provide us with data in their submissions saying that the likelihood of another episode for people who have not had an effective release strategy is extraordinarily high. So that would be one of the core areas that people are considering.

Prof. Lewis—I think that is international research but, particularly if medication got changed or if there are the after-effects of an overdose, they would be critical periods too.

Senator MOORE—One of the things about mental illness is that people can be extraordinarily clever in how they present and how they assure the person treating them that they are going to a certain place. It is one of the real issues. Your view would be that there should be appropriate skills training for the people in the facilities such that they would know that and not be easily conned.

Prof. Lewis—The research and the diagnostic and statistical manual for mental illness says it is very difficult to accurately assess whether or not a person will attempt or complete suicide, but health professionals act as though that is not the case and start to rely on their own judgment.

What that means is best practice would be: this person remains in care until we are sure. Looking at the costs of suicide, the cost of one suicide is enormous for many years to come, and we have not even tracked that cost for, say, a family and friendship network. We do not have any research in Australia that has accurately evaluated that.

CHAIR—What you have just said has been said to us in various ways by lots and lots of people. I do not think I have heard anybody say we can accurately predict who is at risk. The experts that are coming to us are saying what you are saying, yet the practice seems to be something different.

Prof. Lewis—Very different, yes.

CHAIR—So are we just not hearing from the people who think differently? Why aren't we implementing what seems to me to be an extremely sensible way to go?

Prof. Lewis—Because you then have to resource hospitals' emergency departments to actually carry out a better assessment while a person is in their care, and that would be costly. We want to acknowledge that we are in a context where health services are in crisis, and emergency departments in particular are under a lot of pressure over beds.

CHAIR—On the issue of stigmatisation and people not being supported, particularly in emergency departments, we heard some pretty awful stories, especially in Queensland, of patients being essentially punished by both doctors and nurses, and you have raised it as well. I have not heard it in some of the other states. When we were in New South Wales we did not hear the same types of stories, and we heard a little bit in Victoria but certainly not to the same extent as in Queensland. Is it a state by state issue? Have you come across it in all states? Is it something that is fading out now, as awareness of mental health is increasing?

Prof. Lewis—In the community and professions there is more awareness. For example, at the Butterfly Foundation national workshop there were consumers and carers present, and they relayed stories of being dismissed or of being stigmatised and having negative responses. Professionals vary a great deal in their competence, which is another reason to standardise what is expected. I work at University of Canberra and I train a number of professional groups. Nurses can be quite judgmental, for a variety of reasons. We have fantastic mental health nursing training happening at University of Canberra, but not all nurses will have done that training, because it is a specialist area. You can get a culture in an organisation like a hospital that is very negative, and then another hospital can be fantastic. It is not just across state borders; it will vary greatly hospital to hospital.

When a high profile community member suicides, as has happened in the ACT with a senior police officer, I think there is more empathy, so I think that attitudes to suicide are very complex. Because most attitude change happens in the context of a relationship—we know that about sexual health, for instance—lecturers have a good relationship with a small group of students. They have an enormous capacity to bring about attitude change, including a standard to include consumers and carers in the education of health professionals. That would be a great step forward. Students tend to remember human interest stories very strongly. I think that is a great educational tool as well.

CHAIR—I want to move on to the issue of privacy. I think you were here earlier when I was saying that we have heard it come up time and again. You said that you could think of ways we could deal with that. Could we talk about that at bit, because we have heard a lot about the problems—and I agree that there are very, very significant problems there. If the committee can start putting forward some suggestions or can start discussing it, that would be really useful. Can you tell us some of your ideas about how we can work with carers to better inform them but still respect people's privacy—how do we deal with those issues?

Prof. Lewis—I think mental health services are already doing some work with carers and families, because they home visit so they are there, and also because they get contacted by carers and families in an emergency. I think policies around how to deal with families without violating confidentiality will be very important to mandate services to do that work and not be at risk of complaints from the consumers themselves. You can have an intervention that is around dealing with a mental health crisis without the specifics and, if people are at risk in the home, you can have an action plan for what they should be doing, such as recommending they get the police involved and reducing the fear around doing that if they are personally at risk. Again, if there is No Wrong Door in the national mental health policy, then we need to thread down how that happens, how families are welcomed. In my experience, emergency departments in hospitals have much more difficulty in doing that work; they are not as skilled in that area. I think counsellors and psychotherapists have to deal with families, particularly with adolescents and young people. Sometimes that is done by having a different worker to reduce breach of confidentiality and to maintain transparency, and sometimes that is contracted very overtly with the person around what can be told to family members.

CHAIR—So you get a different worker who works with the family, who tells you, around general mental health issues, how you can support a person in a particular situation without talking about the person's specific issues?

Prof. Lewis—Yes—also because carers have such support needs. We know they are very depressed and they are very stressed. They have lived with a lot of threats if the person has had a mental illness for a long time which has made them aggressive, so they deserve services in their own right.

Senator MOORE—This is an exhausting issue. We hear that organisations in areas are struggling to meet their basic care needs in terms of the clients that they have and the waiting lists. Yet the model you present, which I think is very valuable, almost means double resourcing and that cuts into resource funds.

Prof. Lewis—Perhaps mental health services could have services to intervene with families. I know that in drug and alcohol services working with families has been slow to develop, but there have been models like Stepping Stones to work with the families. So there is an awareness developing across a range of fields that it is a very important intervention. Even in low-prevalence disorders, like schizophrenia, there is some high-quality evidence that working with families, for instance, to reduce emotional expression—counsellors often work to heighten emotional expression—working in specific ways, is very effective in reducing hospitalisations. Again, if we put funds here, it might reduce the very high costs of hospitalisations. If we looked at the research, I think we could learn a lot of lessons around reducing acute care beds too.

Senator MOORE—Not so much in this inquiry yet but in previous inquiries consumer groups have been extremely strong about their absolute need to make the decision about how much information is shared with family, friends and carers. I think it has probably been the consumer network that has been the strongest in this area. They are worried about any kind of process that would allow family and carers to have too much engagement in what is happening with them. The model you put forward goes to a certain point, but in terms of the level of emotion and pain that we have had from people, I am not sure—as I said, this truly bedevils me.

You hear the arguments about consumers in mental health being treated like consumers in cardiac care. Whilst we talk about information being shared with family and friends in cardiac, there is not the same input, particularly when in some cases the consumer is actually saying in many ways they see a lot of their problems directly linked to their families and carers. I know I am not giving evidence, but it is always—

CHAIR—These are the sorts of issues we need to explore.

Prof. Lewis—They are the complexities. In an ethical decision-making model, once there is a safety issue and risk involved, the safety issue becomes paramount. For example, in child protection it is really clear that a counsellor or a psychotherapist would need to report once there is clear risk to a child. I think that is true around suicidal risk and risk to the safety of others. Practitioners do need to inform other people when they are at risk. If they have a client in the room who is threatening their family, you do not keep that confidential.

It is pretty clear that it is limited confidentiality. That is one way you can talk about confidentiality—that there are limits to it and, most of the time with clients, that is something we would be contracting in the first session. If there is a risk to the client or to another person, we would need to take some action around that, but we would do that in consultation with them. We would not shut them out of the process. Obviously, there are situations where confidentiality is not paramount.

We have a range of training. Family therapists have a lot of skills working with families. Psychotherapists and psychoanalysts have a more individual approach. So, even within our federation, there would be a range of views. I do not want to be simplistic in what I say.

CHAIR—As per usual, we have run out of time. We really appreciate both your submission and your evidence. It has been very useful. As you can see, we engage a lot in these issues. Thank you.

Prof. Lewis—Thank you.

Proceedings suspended from 10.20 am to 10.37 am

KENNAN, Ms Laura, General Manager, Clinical Support, Crisis Support Services Inc.

MILLER, Ms Alyson, Chief Executive Officer, Crisis Support Services Inc.

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

Ms Miller—Yes.

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

Ms Miller—Good morning, Chair and Senators. Thank you for allowing Crisis Support Services to provide you with further information on the services we provide to people at risk of suicide, their families and carers, or people bereaved by suicide. Laura is going to provide an overview of the services and answer any of your questions of a clinical or practical nature today. Firstly, however, I would like to take the opportunity to give you a brief outline of what Crisis Support Services does—not all of it, but a few highlights, a few key areas of work.

Crisis Support Services has been providing crisis services for over 50 years. We are the only telephone counselling service in Australia with professional, qualified counsellors—qualified psychologists or social workers. We are a member of the American Association of Suicidology, the only member in the Pacific region. We offer anonymity and confidentiality to callers. We are based in Victoria but provide service nationally and we provide a 24/7, free counselling service to people in crisis for the price of a local phone call.

Crisis Support Services works with callers to identify their issues, mitigate any crisis they are currently facing—such as considering suicide—and encourages and supports them to seek other face-to-face assistance through a GP, community health centre, psychologist or other service provider.

In addition to the suicide service we provide, which Laura will elaborate on, I would like to take this opportunity to highlight our other key areas of work. We manage the beyondblue infoline. This provides the general public with access to information and referral for depression and anxiety-related matters such as anxiety disorder, perinatal depression, bipolar disorders and associated issues, including substance misuse. It includes over-the-phone provision of information and appropriate referral to health practitioners, community and support groups and online and hard copy resources. This is a 24/7 service for the cost of a local call.

We manage MensLine Australia, funded by FaHCSIA. This is a 24/7 telephone counselling service for men with family and relationship issues. We receive approximately 50,000 calls per year. Approximately 40 per cent of clients call to discuss a recent separation, which is a high-risk time for suicide amongst men. When appropriate, callers are offered the option of a call-back service, which provides them with up to six telephone counselling sessions with the same counsellor.

We also manage Veterans Line, funded by the Department of Veterans' Affairs. This is an after-hours telephone crisis service that provides professional counselling to Australian veterans of war and peacekeeping operations, their partners and their children. We operate nationally. Callers receive immediate support and we can then refer them to the Veterans and Veterans Families Counselling Services for ongoing face-to-face support, as needed. An addition to this is the all-hours support line, which is a confidential telephone counselling service for Australian Defence Force members and their families. Again, it is available 24/7 and is staffed by professional counsellors. This supports callers who need information and assistance to access the Australian Defence Force or civilian mental health services, including psychology, medical, social work and chaplaincy services. Within Crisis Support Services we also have a designated training department. We provide training and workshops to NGOs and local government on a range of issues, including suicide risk assessment.

Crisis Support Services works collaboratively with governments and other not-for-profit organisations to provide support for their client groups. We acknowledge that our speciality is telephone counselling, so rather than reinvent the wheel we are keen to develop and continue partnerships that support people in crisis when they need it. We heartily welcome conversations with other providers and look forward to robust discussions with our colleagues, governments and members of this house. As you already know, we provide suicide services across the country, including SuicideLine Victoria—the additional support for patients at risk of suicide and self-harm which is within the ATAPS program. We provide the after-hours service and we provide the national Suicide Call Back Service and LIFE Communications.

As you stated, you have read the submission, and I would like to quickly reiterate and expand upon the recommendations we suggest. I note that they are very similar to those suggested by our colleagues in the sector who have previously presented to this committee. In short, we do support the development and funding of a national suicide line that would provide professional counselling to people when they need it and would not be simply an information and referral line. However, the development of such a line would require comprehensive research and collaboration across the sector.

We would like to see more research and service provision for the ageing population and the risks they face, particularly for those who are socially isolated. We know that men over 85 years of age and women in the 70 to 74 age bracket are overrepresented in suicide statistics. We support and would like to look at the broadening and ongoing funding for the national Suicide Call Back Service, which, at some point, we would like to consider linking to the national SuicideLine. This would provide ongoing support for people until they are able to access other professional support. We would also support a continuity of care model for people accessing these services. Using a similar model to the ATAPS program, counsellors would work with other health professionals to ensure that the individual receives the support they need, when they need it, without the requirement to keep repeating their story.

We would also support further targeted services for specific groups who are at risk, including young people and with a focus on young men. I will now hand over to Laura. She will go through each of the suicide services to provide you with an overview.

Ms Kennan—My role is to ensure the quality of the clinical work at Crisis Support Services. I work closely with the training department, the counselling managers, the counsellors and the senior management team to provide clinical advice and models for service provision. I will give you a short overview, in no particular order, of the suicide services provided by Crisis Support Services.

SuicideLine Victoria receives approximately 1,200 calls per month. It is funded by the Department of Human Services and provides 24/7 suicide support to people at risk, carers, those bereaved by suicide and anyone who is concerned about someone they know—for example, a work colleague. SuicideLine Victoria also case manages clients who are linked in with mental health services and other forms of ongoing support. I am sure you will understand that this is a very challenging group of people to work with and requires qualified counsellors to provide the appropriate level of support.

We also provide the ATAPS Additional Support for Patients at Risk of Suicide and Self Harm after-hours support service. This service is funded by the Department of Health and Ageing and is a pilot program running until the end of June 2010. It is currently being run across 18 divisions of general practice. We provide the after-hours component of the service. More recently, an additional five divisions, areas affected by the bushfire in Victoria, were added in to be included in this program.

Our trained counsellors make contact with a person who has been released from hospital or referred by a GP following a suicide attempt. If necessary, we can make contact within a 24-hour period if the division is not able to—for example, after hours or on weekends. The client receives support from the CSS counsellor until they are able to see the psychologist face-to-face. The counsellor notes discussions and issues in a database that, with the consent of the client, the psychologist can then access, saving the client the pain of having to repeat their story a number of times and allowing for continuity of support for the individual.

We also run the Suicide Call Back Service, an important service that offers support nationally to individuals, professionals, carers and people who are bereaved. It has a specific role in supporting people who are at risk of suicide and is funded by the Department of Health and Ageing. It provides up to six 50-minute sessions with an identified counsellor over a period of up to six months. It also provides debriefing support and education to professionals working with people at risk of suicide and can support clients during a time of crisis until they can access ongoing support from a psychologist, general practitioner or other mental health worker. The open line allows carers, people worrying about someone or the bereaved to call and get access to crisis support when they need it.

We understand that you have heard some information about the LIFE Communications project. We take this opportunity to provide you with further information about the project and what we have achieved. I would first like to say that we have noticed that in previous sessions this has sometimes been referred to as the CSS Hub. This service is in fact marketed as LIFE Communications; therefore, some people may not have recognised it under the name of CSS Hub.

Living Is For Everyone, or LIFE, Communications—which I will refer to as LIFE Communications from here on—was established to support the National Suicide Prevention Strategy. It is funded by the Department of Health and Ageing until the end of June 2010. It delivers a suite of national communication activities for organisations working in suicide prevention, including improving channels of communication between key stakeholders. It is a very important program, and we have achieved a lot, including the dissemination of information nationally and internationally and a mailing list of 3,200 subscribers—primarily not-for-profit and community organisations, mental health clinics, GPs, divisions of general practice and a few academics.

Since July 2008 the website livingisforeveryone.com.au has had approximately 205,000 page views and 70,000 visits. Downloads have included the framework, 5½ thousand times; research and evidence documents, 5,000 times; a full set of fact sheets, of which there are 24 in total, 3,000 times; and fact sheet No. 3, ‘Statistics on suicide in Australia’, 10,100 times. The LIFE Communications team have also attended a number of conferences and run workshops where they have provided hard copies of the resources to approximately 2½ thousand organisations. In addition, since our submission to this committee, the LIFE evaluation workshops have started. Approximately 350 people have enrolled across eight cities nationally. The workshops are free and introduce a basic model of project evaluation that can be applied to a range of activities which aim to prevent suicide.

We have brought with us a LIFE USB for each of you which contains the resources suite, the framework, the fact sheets and research and evidence documents. I would also like to add, if I may, that CSS was funded to develop and deliver 17,000 DVDs to health professionals nationally, regarding working with rural men at risk of suicide. We have a copy of that DVD for each of you today. Thank you.

Senator MOORE—Ms Kennan, I still do not understand what you do with the hub. I have been asking questions about whether people know about it. If you have a look at the questions you will see that I asked not just about the hub but about the whole project. As you will see from the evidence, a number of organisations said that they did not know you. I think that is an issue. But I am more interested in the fact that I just do not know how it works. I appreciated the submission about the phone hook-ups and I understand fully the ATAPS funding. But I do not understand the pulling together of communication strategies. I would really like to find out how it works. Who pulls the things together? How is the communication done? Is it supposed to be a base so that people can look at the website and find out what is going on in suicide prevention activities around the country? Who is responsible for putting that information there? I have not been able to find that out.

Ms Kennan—The LIFE Communications team pull it all together for the website.

Senator MOORE—Who are they?

Ms Kennan—They are staff employed by our service.

Senator MOORE—Do they have another role? Are they just doing this job?

Ms Kennan—That is correct.

Senator MOORE—And at this stage they are funded up until June 2010.

Ms Kennan—That is correct.

Senator MOORE—How many are there?

Ms Kennan—Four.

Senator MOORE—What do they do?

Ms Kennan—They research the current literature. They make sure that the website is kept up to date with the latest news and research. They produce a newsletter which people from different organisations can submit articles to, to raise awareness of what is going on in the community. They are also constantly updating what is going on in the community. As you can see on the website, there is a section that talks about all the federally funded National Suicide Prevention Strategy activities and also the community based activities. When the framework was originally developed it was mailed out to 3,200 organisations. People found out about it initially from there and have been able to subscribe to the mailing list and receive the newsletter and any updates that come out. There are also online forums run on the website. There is a library which contains information about the latest research and other fact sheets that can assist people in knowing about the best ways to tackle suicide, what is the evidence base for those activities and what else is going on in the community.

Senator MOORE—So it is reliant upon organisations or people who are interested in giving that information to it. It is not someone’s role to go out and find the information; it is more to act as an information hub for other people to feed into.

Ms Kennan—That is correct. People can submit and upload information through there. They regularly attend conferences and workshops nationally to make sure that people can find out more about the communication project.

Senator MOORE—So basically it is an information process.

Ms Kennan—Yes, for professionals and organisations that are working with people at risk of suicide.

Senator MOORE—What about individuals?

Ms Kennan—Individuals in the community would not particularly know about LIFE Communications because it is aimed at raising awareness amongst organisations and health professionals about how to provide quality evidence based suicide prevention activities. They are the target groups.

Senator MOORE—Can individuals who want to subscribe to the newsletter do that?

Ms Kennan—Absolutely.

Senator MOORE—How does it link in with the research? It came out through the discussion about research, because one element of our terms of reference is looking particularly at research. The other people who have received money specifically for research are Griffith—how does it interact with the Griffith research base?

Ms Kennan—I would need to get back to you on that.

Senator MOORE—So Griffith would be a subscriber?

Ms Kennan—I would imagine so but I would need to check.

Senator MOORE—I am interested in the statement that you are the only feedback line or telephone area that has accreditation from the American group. What is the status of that? The American group and accreditation have not been mentioned in any other thing that I have read on this issue. So that claim jumped out that you are the only ones accredited and I want to know what that means.

Ms Kennan—The American Association of Suicidology have a particular set of standards that organisations that are accredited must adhere to, and to ensure we maintain best practice and have the highest possible standards we wanted to seek accreditation through them. We are the only organisation in the Pacific region to have that accreditation.

Senator MOORE—Does that actually mean that you have a particular status or is it just in terms of best practice standards?

Ms Kennan—It means that the quality of our work is recognised as being of a very high standard. There are particular guidelines about the way in which you provide your clinical work and the way in which your training is delivered that must be adhered to in order to maintain your accreditation with the AAS. We get audited once every five years and have a self-audit every year to ensure that we comply with standards.

Senator MOORE—Certainly one of the recommendations that is coming up across many of the people who have provided evidence is that there should be a national crisis line. One of the other aspects of that is that it should be free, because the cost of it has come up consistently. Your services are not—is that right?

Ms Kennan—Our services are the cost of a local phone call—

Senator MOORE—Or mobile.

Ms Kennan—If you are calling from a mobile—but there is no cost for the actual service beyond that.

Senator MOORE—Just the cost of the phone call. I saw that you had the ATAPS contract, which I think is a very exciting model in terms of personal support and so on. That is based on a call-back process.

Ms Kennan—There are three ways a person can access the service. As you know, for that project the psychologist in the division is supposed to make contact within 24 hours. If, because it is six o’clock on a Friday night, that is not going to be possible, the GP or the psychologist can ask us to give them a call. The psychologist has also got cards with our number on it which they can give to their clients and say, ‘If you’re struggling out of hours, you can contact this service and they’ll be able to support you.’ Also, if the psychologist is concerned about a client they are seeing through this program, they can contact us with the consent of the client and say, ‘Would you mind giving this person a call on Saturday evening,’ and we will give them a call in that instance just to check in and make sure they are okay.

Senator MOORE—So that is funded through the ATAPS direct funding?

Ms Kennan—Yes, it is through the additional support for people at risk of suicide.

Senator MOORE—So there is extra funding for that service.

Ms Kennan—Yes.

Senator MOORE—My question was leading to: if you have issues of people who have a high cost in terms of calling do you have an established process for calling them back?

Ms Kennan—Yes.

Senator MOORE—Do you have any records of how often that is done?

Ms Kennan—I think we would be able to get records of it, yes. Certainly we have records of our incoming and outgoing calls.

Senator MOORE—It is a common statement from people that the cost could be difficult for them. To take the anecdotal comment that people will not call because it costs too much, if you have an internal process that says you will call them back I would like to know how often people access it, to balance that up.

Ms Kennan—Yes.

CHAIR—How do people know? Do you tell them, ‘We can call you back’? If they are calling on a mobile, is it only when they say, ‘I can’t talk much longer because I can’t afford it,’ or do you say upfront, ‘We can call you back’?

Ms Kennan—Generally speaking, if they say that the cost is a problem—often they will say, ‘Can you call me back?’—we will call them back.

CHAIR—If you could provide us with that information, it would be very useful. I want to follow up on the ATAPS issue. Senator Moore asked a couple of the questions I had around that. How long have you been doing that particular project? It finishes in a couple of months time.

Ms Kennan—I will just double-check my dates. I believe it commenced at the end of 2008.

CHAIR—That means you will have been doing it for 18 months?

Ms Kennan—Yes.

CHAIR—Is there an evaluation process when it finishes in June?

Ms Kennan—No, because when it started the after-hours service was projected to receive 100 calls per year and to date we have received over 250 calls, so the uptake has been greater than what we thought it would be. No evaluation process was put in place.

CHAIR—I may be misquoting what you said here, but I thought you said it was a trial.

Ms Kennan—Yes, it is.

CHAIR—So, if it is a trial, why isn't there an evaluation process?

Ms Kennan—I am not sure of the answer to that. I am not sure if the project being run in the divisions, the face-to-face component, is being evaluated. That might well be evaluated. There is no evaluation at this point of the after-hours service.

Ms Miller—We do, however, provide reports back to DoHA on that service on a regular basis. We will be providing information, providing the reports, to them.

CHAIR—What sort of information are you providing: the number of callers—

Ms Kennan—The number of callers, whether there have been callers within the first 24 hours of the psychologist requesting call backs, the number of clients calling directly, how many callers we have spoken to more than once, and the days and times we received the calls from these people. They are the general things.

CHAIR—Obviously, what I would be looking for in an evaluation is the effectiveness of the service. While I appreciate it is good to have the numbers, the quantitative data, it would be very useful to have an evaluation of the effectiveness of the service. The follow-up when people leave care has come up time and time again as an issue. It sounds like a similar service is about to be trialled in Queensland with a couple of divisions. Because it is yet to be announced they were not able to provide us with details. It sounds like they are trialling something similar in Queensland. It sounds like it is a valuable service. Certainly you indicate that the numbers are double what you expected. I would dearly love to know what evaluation process will be undertaken. We will obviously follow that up with the department.

Ms Miller—We will certainly welcome the evaluation process as well.

CHAIR—The problem is that it is just about to finish. Sorry, I am on one of my hobbyhorses at the moment. The problem with these programs is a lack of evaluation and lack of evaluation put in place at the beginning of the process, not tacked on as an afterthought.

Ms Miller—I think it also ties in often with the short-term funding. Often for organisations—and I am not saying that this is the case for Crisis Support Services—if it is not locked in at the beginning, you are too focused on the delivery of the service if you have been given a year to do the work.

CHAIR—I totally understand that. This committee in particular is very used to, and does not like in general, short-term funding of projects—certainly I do not. We have commented on it before in a number of our reports. I am aware of that. Why was it funded for only 18 months?

Ms Kennan—Originally it was funded for six months from November 2008 to May 2009. Then it was extended by another six months and then another six months again.

CHAIR—Is it likely to be extended again?

Ms Miller—We do not know. We have not had the conversation. That is an issue as well—and we mentioned that at the beginning of our statement—the lack of knowing. It is all very well for a contract to come to an end but you do need to know what is happening at a sooner date.

Senator MOORE—Would you recommend it be continued? I think that is the bottom line.

Ms Kennan—Absolutely.

Senator MOORE—You people are doing it. You have got arguments as to why it should be.

Ms Kennan—Yes.

Senator MOORE—Were you asked before the last two extensions for your opinion of the program?

Ms Kennan—No. I think it was funded for the initial six months. Anecdotally, what happened was that some of the on-the-ground services—that is, the divisions and the psychologists getting up and running—took a bit longer than anticipated. They did not get up and running until a little while into the program and, therefore, had not been operational for six months at the end of that period. Because we are doing the after hours for them, the service we run depends on what is happening at that level.

Senator MOORE—So it is not a standalone service; it is linked to the wider program?

Ms Kennan—That is correct. The benefit of this service is that the information is shared, with the client’s consent, with the psychologist, so on Monday morning the psychologist walks into their office and knows what conversations and difficulties the clients have had over the weekend. The clients calling can choose not to share that information, in which case we will not. But most of the time they agree to have the information shared, and it allows for greater continuity of care. Certainly that would be a great model to carry on with.

CHAIR—Are all your services provided through that program after hours? For example, if someone cannot get hold of their psychologist or clinician at the division during working hours, if they are in crisis can they phone you through this process, or does it have to be after hours?

Ms Kennan—The service is funded for after hours, but the line is operational 24/7 so we do sometimes get calls during the day, and we take those calls.

CHAIR—What proportion would be calls to you versus calls from people in which you are requested to call back?

Ms Kennan—Off the top of my head, I believe the proportion would be about 50 per cent coming in from clients, about 30 per cent from psychologists requesting us to contact clients over the weekend and about 20 per cent is that first contact within 24 hours. I would need to check those figures.

CHAIR—We would appreciate it if you would do that. I want to go back to the evaluation. I would like to know whether people find this service really helpful. I would think people would and, judging by the number of phone calls, they do, but has there been a survey of clients to see whether they value the service?

Ms Kennan—Not of that project. In a similar way we run the Suicide Call Back Service, which offers clients six call-back sessions with the same counsellor over six months. A crisis component has now been built into that whereby people who are struggling between sessions can call us, or if health professionals are working with people who need support between sessions they can contact us. That program is in its second round of funding and is being evaluated, but it was evaluated the first time round and was found to be very successful.

CHAIR—What happens if people need more support than six sessions over the six months?

Ms Kennan—We take it on a case-by-case basis. The aim of the phone service is, ultimately, to link people with support in their community. But, due to waiting lists and a lack of services in some communities, we see ourselves as a holding pattern. We are not trying to duplicate what is happening on the ground; we are trying to fill in the gaps with the service. If after six sessions someone still has not been able to get in to see someone, we would certainly keep supporting them for as long as they need.

CHAIR—What proportion of your clients would be regional? We have had a lot of evidence about regional and rural clients and their lack of access to support services. What proportion of your clients would be from regional and remote areas?

Ms Kennan—I will need to get back to you with that figure, but there is certainly a significant proportion from those areas.

CHAIR—That would be very much appreciated. If you have those figures, could you also tell us how many of those people have to continue after their initial six months because they have not been able to access other services?

Ms Kennan—Yes.

Senator MOORE—Ms Kennan, you have a large bank of phones, which I am trying to visualise. You have a number of programs for people using them in the same way that they use Centrelink call centres, which do work for other agencies. Do they have different phone numbers, or is it just a matter of identifying themselves and what service they want to access when they call?

Ms Kennan—No. Every line has its own number. The counsellors on a particular shift are working on just the one service. They receive a whisper in their ear to remind them of which service it is before the call comes through—a whisper is an automated thing in the telephony system.

CHAIR—So, they are only working on one particular service for each shift they are on—is that what you just said?

Ms Kennan—Yes.

Senator MOORE—But they would be workers employed by the agency and their professional skills would allow them to work across the different areas?

Ms Kennan—Yes.

Senator MOORE—They are actually allocated. Do you have a program of making sure people move through them, to widen their skills? Is that part of the process?

Ms Miller—Yes. In fact, it is pretty much a necessity for the organisation as well, because we find that, with the different lines, the staff need the diversity. It is quite difficult to be on SuicideLine Victoria every day. Given the nature of their qualifications and experience, they can then have a day on beyondblue or MensLine or whatever it may be. That really helps shape the development of the staff.

Senator MOORE—Are the people working on MensLine all men?

Ms Miller—No. In fact, almost 50 per cent of the staff on MensLine are women.

Ms Kennan—We do annual call satisfaction surveys and ask what gender counsellor the respondent had and whether they would have preferred to have a counsellor of the opposite gender. Ninety per cent of the time they are more than happy with whatever gender they got.

Senator MOORE—As long as they got some help, they did not really care?

Ms Kennan—Yes.

CHAIR—We have had some evidence to suggest that men, in particular, want to talk to men. If they get a woman, can they request to talk to a man?

Ms Miller—Absolutely.

Ms Kennan—Yes, absolutely. Just going back to the shift times, the only exception to not being on the one line is overnight, when it is very quiet and we receive very few calls. In that case, the counsellors might be able to take calls on more than one line for that shift.

CHAIR—We have had a bit of evidence about people needing to access the services at night—

Senator MOORE—When they need it.

CHAIR—When they need it—they are in crisis. What proportion of calls would you get at night?

Ms Kennan—It depends on the line, but generally our busiest time on the suicide prevention services is, off the top of my head, between about 6 pm and midnight—that evening period after work and before people go to bed.

CHAIR—I had one other question, but it has gone out of my head. I may need to give it to you on notice if I cannot think of it. Senator Humphries, did you have anything you wanted to ask?

Senator HUMPHRIES—No.

Senator MOORE—Have you done assessments of busy times and things that stimulate calls and all those things? One of the things that SANE Australia was talking about yesterday was an ongoing concern that people had about different community activities stimulating concern. It can be something national, like the highly publicised profile of a case—someone famous—or something particularly horrific.

Ms Kennan—Yes.

Senator MOORE—They were also talking about the fact that people's own commemorative dates are all over the place, so people would see something in the media that would stimulate their own concerns. Have you done any work on what happens if there is a major case of someone famous committing suicide and whether there is a link to the impact on your phone lines after that?

Ms Kennan—Generally speaking, we do see an increase if there is something major going on that has been in the media, in which case we make additional staff available to be called in at short notice should they be required. Often we will roster on additional staff in advance just to make sure that there is enough staff there, but it does tend to be with those peak media opportunities.

Ms Miller—We also have to analyse and forecast for the organisation's benefit. We have a staff team of 144, of which 112, I think, are counsellors. The counselling centre operates at, I think, a maximum of 30 staff per day, and we have another site with another 15.

Senator MOORE—So you have a couple of sites? It is not just one big location?

Ms Miller—Yes. We have a larger location—the main office—and a smaller site, and we have to forecast and predict, because we are rostering. The great thing about being 24/7 is that we do have the staff on. We know we have the qualified staff and because they are multi-skilled it means that if there were a quick crisis then we have confidence that we could, in the very first instance, answer the lines. And as Laura said, we can put on more people—

Senator MOORE—As required.

Ms Miller—as required.

Senator MOORE—What about access to language interpreters—is that built into your planning?

Ms Kennan—We use the telephone interpreting service.

Senator MOORE—I know how that works, but how does it work in your particular work?

Ms Kennan—If people who ring up need it, we get their phone number, we contact the interpreting service and the interpreting service do the three-way link from their end. It is a bit awkward at first for people but, once they have used it a couple of times, they get used to the way it works and it is fine.

Senator MOORE—What about the response times? Part of your job is immediacy in getting crisis support. Do you have problems with getting feedback quickly?

Ms Kennan—From interpreting services—to my knowledge, no.

Senator MOORE—We have heard that people in crisis often revert to their home language, so having an interpreter is a particular need. If there is something going wrong, people do not always have the time or capacity to translate into a second, third or fourth language.

Ms Kennan—Yes, I imagine that for people in distress that would be very difficult.

Senator MOORE—What kind of data do you keep on the people who call in—age, ethnicity, gender? Is there set data you try and get for your statistics?

Ms Kennan—General demographic data is collected by all our services—in most cases, they are contracted to collect that data. It is the usual categories: age, gender, location, state, ethnicity and themes and issues. It depends on what line the callers are on. For example, on MensLine we collect more information on whether or not they are in a relationship, whether they are living with their family or they are living alone and whether they are renting or they live in a house they own. On the suicide service, the questions relate more to their level of suicide risk, their access to supports and creating safety plans. So, apart from the demographic information, the information varies depending on the nature of the service.

Senator MOORE—What about sexual preference? I know you cannot just ask that straight out—it would be a little insensitive. I am just wondering about the process. We have had evidence from the collective group on gay and lesbian, transgender, intersex—

CHAIR—The LGBTI community.

Senator MOORE—on different health providers in that area, and they feel that there is a particular gap in servicing their members. They feel as though, in different places, they may face more discrimination when they are trying to seek services and, at different times, may be subject to more depression. I would never question how you find out that information—that is part of the skill base—but is it something you keep?

Ms Kennan—I think it might be listed in the MensLine database, but I would need to double-check. It is not listed—

Ms Miller—It is not a requirement.

Ms Kennan—It is not a requirement, no. Certainly with the suicide service, if it came up as a risk factor for someone, it would be listed in the risk factors section as one of the pertinent issues for that person.

CHAIR—I wanted to ask about training. You went into a bit of detail about your training, including in the submission. We have heard a lot about the lack of training for people working in the area, particularly, for example, training in mental health issues for nurses. What is your remit in terms of the training that you provide? How wide can you go in providing your training? Is it limited to people in your helpline services, or do you go broader?

Ms Kennan—We have compulsory internal training units that all our counsellors must complete, which are in alignment with our AAS requirements. We also do external training for other organisations. Recently we have done training for organisations including Centrelink and the Financial Ombudsman. A range of organisations seek training in things like suicide risk assessment and how to work with difficult people. We train organisations like Centrelink in managing upset callers. A lot of organisations particularly want training in communicating effectively with men.

CHAIR—Is it training in providing services just over the phone or face to face as well?

Ms Kennan—Face to face. We go and train them in doing that in their face-to-face work.

CHAIR—Are you funded to provide that or, particularly where you train external services, do they have to commit some funding to enable you to do that?

Ms Miller—For some of our projects there is a training component so we provide that training, which is what we want to do, particularly for the NGO sector. The requests for training far outstrip the supply. We do not have a large team, and that, I have to say, is because of funding. I think it is fair to say that we have to be strategic with our training. We have to first and foremost look at the project demands, and then we assess the needs thereafter. In regard to Centrelink, we charge a fee—we try and make it reasonable. Beyond that, we try and encourage organisations to get together and share the costs of the training. It is an issue, and we can certainly provide evidence on the number of requests that we receive.

CHAIR—That would be very much appreciated. If we can start building up some evidence around that for our report, it would be very useful.

Senator MOORE—Particularly as people say in their recommendations that they think that should happen. It would be very useful to know what the demands on your organisation have been. Is your Centrelink contract just in Victoria or is it across the country?

Ms Kennan—It has just been in Victoria so far. It has been session by session.

CHAIR—Has it been by area? We can follow up with them.

Ms Kennan—I believe there is a state psychologist who takes care of the statistics. We have been doing it through him. Some have been in Melbourne and some have been in regional areas. On training, we noticed when we first ran the Suicide Call Back Service that there were a lot of professionals working in mental health, psychologists and social workers, who did not have training in how to conduct suicide risk assessments. So we have built into the renewed contract for the Suicide Call Back Service support for professionals working with people at risk. We offer them call-backs as well, so we can follow up with them and say, ‘How did you go?’ once we have gone through all the educational things with them on the phone. They can also call in for debriefing.

CHAIR—Thank you very much. We have given you quite a bit of homework; I hope that is okay. I must admit I am always careful not to give NGOs lots and lots of homework because I know that it takes time away from what they are supposed to be doing. But what we have asked for would be extremely useful for us. If you would not mind providing that, that would be great.

Ms Kennan—Absolutely.

CHAIR—Thank you very much, and thank you for coming out to talk to us.

[11.24 am]

BROMHEAD, Mr Richard CW, Manager, Mental Health Policy Unit, ACT Health

LAMBETH, Dr Leonard, Acting Director, Clinical Services, Mental Health ACT

CHAIR—Welcome. I understand you have been given information on parliamentary privilege and the protection of witnesses and evidence. As departmental officers, you will not be asked to give opinions on matters of policy, though this does not preclude questions asking for explanations of policy or factual questions about when and how policies were adopted. Thank you for your submission. I invite you to make an opening statement.

Dr Lambeth—We would like to expand on our initial submission to the inquiry. I will undertake to provide an overview of mental health services in the ACT and to highlight the clinical activities being undertaken regarding suicide risk and the prevention of suicide. Mr Bromhead will provide more information about the ACT suicide prevention strategy and the initiatives occurring within the policy arena to address suicide prevention.

ACT Health is a small jurisdiction with one mental health service. The ACT *Mental health services plan 2009-2014* articulates the vision and strategic directions for the development of the mental health sector to 2020. *Managing the risk of suicide two: a suicide prevention strategy 2009-2014* and *Building a strong foundation: promoting mental health and wellbeing in the ACT 2009-2014* are subplans of the services plan and set out the ACT's whole-of-government commitment to suicide prevention and mental health promotion. We have quite a commitment to suicide prevention and we ensure that all clinical staff have the skills and resources to identify and manage consumers who present with suicidal ideation and/or self-harm. The training is also open to alcohol and drug employees and to staff of NGOs. Our training includes mental health and alcohol and drug staff and those employed in housing support agencies funded under the National Affordable Housing Agreement.

Awareness of suicide and strategies to prevent suicide are further enhanced in the ACT through the delivery of strategies by the Mental Health ACT forensics team. This team provides education, training and support to corrections staff at the Alexander Maconachie Centre and the Bimberi Youth Justice Centre in the management and support of at-risk detainees. We support clinically managed consumers through a variety of services which are very strongly recovery oriented. These include full mental health and risk assessment of any individual presenting to the emergency department of the Canberra Hospital with suicidal ideation, attempted suicide or self-harm. On 7 April we are going to open a mental health assessment unit which will be present in the emergency department and part of the emergency department, where we feel we can do much better assessments.

We offer clinical management of consumers who have a mental health problem and are at risk of self-harm or suicide. We have inpatient services located at the Canberra Hospital in the psychiatric services unit. This is a 30-bed unit and services the population of the ACT. We have another unit located at the Calvary hospital known as ward 2N, which has 20 beds. We have a Step Up/Step Down facility which is located in Canberra and caters for those people who may require hospitalisation but are not quite at that stage as yet and also those people who have been in hospital and who may rejoin the community but are not ready for completely independent living.

With respect to our forensic clients, our new prison has been a focus for the ACT. We have comprehensive assessment management plans for those identified as requiring ongoing mental health management. Indeed, every single prisoner who comes into the facility is given a mental health assessment. There are three possible results of that: they have a mental health problem, they do not have a mental health problem or we are uncertain. For the people about whom we are uncertain and for those who have mental health problem, we do a much more complete assessment, which may take several hours.

Our forensic team has introduced a seven-day follow-up for detainees released from the prison. Those detainees who have been clinically managed by us while in the prison have this seven-day follow-up. We are fully aware that the period of time immediately after release from detention is a time of great risk. We are also seeking funding to introduce a real understanding in self-harm program, which is a DBT based program for prisoners. People who repeatedly self-harm are of course very difficult to deal with, and we find that DBT programs are the best at giving an understanding of the reasons for self-harm and helping them to develop techniques not to self-harm.

We certainly try not to forget the bereaved families of those who commit suicide. Given the relationship between the higher incidences of prolonged grief reaction in survivors of suicide and the very real stigma that is associated with suicide and mental health issues, we offer a great deal of support to family members bereaved by the sudden death or suicide of consumers of Mental Health ACT. We feel that this is a very important aspect of our work.

Mr Bromhead is going to enlarge further on the policy issues, and with your permission I would like him to do so.

Mr Bromhead—Thank you very much. I would like to provide a little bit more information on the suicide prevention activities in the ACT from a policy perspective. In September last year the ACT government launched the new youth suicide prevention plan *Managing the risk of suicide two: a suicide prevention strategy 2009-2014* and its promotion and prevention and early intervention framework *Building a strong foundation: promoting mental health and wellbeing in the ACT 2009-2014*. The strategy and the framework are linked documents and travel together, as promoting health and wellbeing is itself a suicide prevention strategy.

The strategy was built in close consultation with the community sector but reflects the LIFE framework, the National Suicide Prevention Strategy document. Both the strategy and the framework documents were endorsed by ACT cabinet in September and both documents linked through the five major human service agencies in the ACT government and have commitments from those agencies. So the Department of Justice and Community Safety, the Department of Education and Training, the Department of Disability, Housing and Community Services, ACT Health and, for some things, Territory and Municipal Services have also committed to implement both the strategy and the framework but also report back to ACT Health on that implementation.

Picking up the previous theme of evaluation, Professor Kathy Griffiths from the ANU Centre for Mental Health Research is on the suicide prevention committee, and Professor Deb Rickwood is on the mental health promotion implementation committee. At the moment we have proposed that all of the information that is reported to ACT Health be reported through an instrument the Centre for Mental Health Research has developed. So not only will it have our implementation reports coming back in for the government and reporting to cabinet; we are also seeking to have this, over the five-year life of both the framework and the strategy, researched by the Centre for Mental Health Research, in collaboration with Professor Deb Rickwood at the University of Canberra school of psychology, looking both at what is happening as policy implementation and at how strategies actually work in this sort of context. Professor Kathy Griffiths and Professor Deb Rickwood have informed us that they believe that this is the first time, probably internationally, that strategies of this sort of human service nature have been put under this sort of scope over the life of their implementation.

At the moment it is a proposal, because we are travelling through the ethics committee process. We have to go through both the ACT Health ethics committee and the university ethics committee. From the researchers' side in the university and from us there is commitment to progress this and bring it to fruition.

Senator MOORE—Can you do both ethics processes at the same time?

Mr Bromhead—The information to us from Professor Griffiths is that the ANU would prefer to see the ACT Health ethics committee do their work first. I suppose it helps guide them, but it may also make their job a little easier if they can see the documentation that our committee has checked it. So the advice is, 'Please do yours; we'll do ours subsequently.'

With some of the activities that come in under the suicide prevention strategy—particularly, for example, in the Department of Education, Youth and Family Services—the ACT government in the last budget committed an additional $200,000 per year for the next two years to enhance the roll-out of both KidsMatter and MindMatters. That was in addition to the additional funding that came after our budget announcements through the Commonwealth as to the enhancements of the roll-outs of those programs. As part of enhancing the whole-of-school community, it is to enhance teachers' understandings of mental health and wellbeing and also risks with that.

The department of education has also committed to training their counsellors with the ASIST program with suicide-specific information. They are looking at how they are rolling out safeTALK, which is the lower level understanding of suicide for teachers in a general way. That is across the public education sector. With KidsMatter and MindMatters, the ACT government enhanced funding is for the entire school sector, independent and government.

The Department of Justice and Community Safety, in the same budget initiative, also received $100,000 per year to enhance their training for emergency service workers, and that is specifically targeted at the police and ambulance officers, who are often the first-line responders. The police and ambulance services are currently looking at some of the combined options for training and how they are implementing those services with the additional capacity. In addition, the Australian Federal Police in Canberra have a very close relationship with a non-government organisation called SupportLink. Where there has been a sudden traumatic death or a suicide, the police refer families of people who are closely involved in that death to SupportLink. SupportLink then helps those people to access appropriate services around their needs.

An example of a program that the department of housing and community services would report to us under the National Suicide Prevention Strategy would be a program called Impact, which is an integrated multiagency for parents and children together. It is designed to strengthen service provision and collaboration for families of women who have children less than two years old who are clients of Mental Health ACT or who are receiving opioid replacement therapy. The impact program is to wrap services around those families to support them and support the children in those contexts.

At an ACT government level we fund programs such as OzHelp and Lifeline for their ASIST and safeTALK training packages. OzHelp was the initiative of a previous government and has been supported by the continuing government.

Senator HUMPHRIES—Do you mean the ACT or federal government?

Mr Bromhead—Local ACT government. It has been rolled out nationally from the ACT. It was an innovative program.

CHAIR—We had them present evidence.

Mr Bromhead—We are very proud of them. In the area of stigma reduction in schools, the ACT government funds an organisation called MIEACT, Mental Illness Education ACT, to provide mental health literacy programs in schools and, as part of that, they use carer and consumer presenters. It is mainly targeted to the older school levels, around years 8, 9 and 10. They received additional funding in the last budget because of the demand on their service. Other early interventions for young people with emerging mental health problems in the ACT include the Commonwealth funded headspace. Additionally, working in the schools is the Belconnen Community Service, which is funded for a program called Bungee. There is about $288,000 for the Bungee program, which is targeted at 15- to 18-year-olds and their families, and they work very closely with the department of education. Thank you.

CHAIR—That is a comprehensive rundown. Thank you.

Senator HUMPHRIES—Thank you for that outline of what is going on in the ACT. How many officially recorded suicides are there in the ACT each year?

Dr Lambeth—We have the official rates by gender from 1992 to 2007. The highest number was in 1999, when we had 45, and the lowest number was in 2002, when we had 24, so it varies between those numbers. The number for 2007 was 31, males being more frequent than females.

Senator HUMPHRIES—You mention in your submission that there is a problem with underreporting of suicide and the need for more standardised systems of reporting and better data consistency. Would you like to hazard a guess as to the extent of underreporting—in other words, what would those figures be if there were more accurate reporting?

Mr Bromhead—It is really difficult in the ACT to hazard a guess on that. I will give you another juxtaposition of the figures Dr Lambeth has just given you. In 1992 the total number was 31 and in 2007 the total number was 31, and it has bounced between 24 and 45 within those periods. Our figures are so small that rates get affected by very small changes per year in what happens.

Nationally, I understand that last week the ABS was going to release revised figures for 2007. There was an indication there might be some change in that data by about 25 to 30 per cent at a national level. I would not like to guess that within such a small number it would or would not be that. Locally, people like SupportLink do say that anecdotally they would feel that the number is underrepresented. I would not like to guess by how much.

Dr Lambeth—One of the well-known areas that is considered underrepresented is the suicide of males by motor vehicle. I think that across most areas we recognise that there are many so-called motor vehicle accidents that are suspected strongly to be suicide. And then there is, of course, now the National Coroners Information System, which does take some time to record a suicide.

CHAIR—They are trying to address that.

Senator HUMPHRIES—And you say in evidence on that underreporting:

> … emergency workers and others who are frequently first on the scene at motor vehicle fatalities report that indicators such as notes in single vehicles are frequently overlooked during coronial determinations.

How does that come about?

Mr Bromhead—I do not know how that comes about in coronial investigations. We are reflecting the anecdotal evidence that was given to us by agencies such as SupportLink or in talking with ambulance officers. It is indicative, and I do not have stronger evidence than that.

CHAIR—That is consistent with other evidence we have received in other states as well—that there is that error because of stigma, not wanting to name it, family issues and life insurance.

Senator HUMPHRIES—Hopefully the families get these notes.

CHAIR—That is a question. Do they get passed on to the families even if they do not get reported?

Mr Bromhead—I would have to ask the Australian Federal Police and the ambulance services that question.

CHAIR—It would be appreciated if you could.

Senator HUMPHRIES—Just in respect of that, I could understand if there were some underreporting for those reasons. We obviously all agree that more accurate reporting of numbers of suicides is desirable. Could you conceive of a system of an unofficial suicide list for the purposes of national figures, at least, where you would submit the details of situations like the single vehicle deliberate accident but not report it in more immediate coronial proceeding as a suicide? Is that kind of official/unofficial list a possible paradigm that you could use to overcome this problem?

Mr Bromhead—I think it would be possible. It would certainly give us information that we do not currently have. Any information on what might have possibly been a suicide is going to help us to understand this extraordinarily complex process so much better. But, of course, there is the problem, if it were official, if it were made public in some way, of the stigmatising issue.

Senator HUMPHRIES—Do you have a figure for the cost of the ACT suicide prevention strategy?

Mr Bromhead—The suicide prevention strategy as a whole over the five-year period? No, I do not. The strategy has two components. One is the services that government and non-government organisations agreed to report to us that they are currently implementing or plan to implement within the funds that they have over the five years, and then there is the aspirational action that strategies have of helping to move forward, provide the evidence and bring us to where we need to go in that sense. The strategy was not funded in that budget sense.

Senator HUMPHRIES—Are you saying programs that are part of that strategy or associated with that strategy, like IMPACT, are not labelled as suicide prevention strategies at the level of individual agencies?

Mr Bromhead—Not necessarily. Some, like ASIST, safeTALK and IMPACT, would definitely be. The factors affecting suicide in a community are as much around the social determinants of health and wellbeing as they are around mental illness directly. So services like IMPACT that support vulnerable people will have an impact on suicide if the service is dealing with their mental health issues and their issues around drug dependency as well as their connection to agencies that support their family life and things like that. It can be quite difficult to say to what extent the services we promote as suicide prevention services, on which government and non-government agencies have agreed to report to us within the suicide prevention strategy, are suicide prevention specific.

Senator HUMPHRIES—I assume as the strategy rolls out, though, you will be in a position to report to the legislative assembly on changes in culture in some organisations—which might contribute to better understanding of what is going on, linkages between agencies in dealing with cases across those agencies' boundaries and things like that—to get a sense of whether or not the strategy is succeeding.

Mr Bromhead—We have built that reporting into the implementation of the strategy. We hope that we will be able to research that stuff during the five years, through our program with the ANU and Canberra university.

Senator HUMPHRIES—I assume there are no progress reports yet because it is still in its early stages.

Mr Bromhead—We are finalising the details of the reporting. There are about 180 different reporting elements for the two strategies. For a jurisdiction the size of the ACT, it has been a massive task. I acknowledge the work of our suicide prevention officer, Dr Johann Sheehan.

Senator HUMPHRIES—There is no other jurisdiction that you know of that is attempting this whole-of-jurisdiction exercise.

Mr Bromhead—From a research point of view, not that we are aware of or that Dr Kath Griffiths and Dr Deb Rickwood have been able to find.

Senator HUMPHRIES—It is very commendable. I hope we can get more information about this as it rolls out. You talk about the risk of subsequent suicides when a family experiences a suicide. Again, I suppose it is nearly impossible to accurately record such things, but do you have any sense of how many subsequent suicides might occur in this community each year?

Mr Bromhead—I could not comment on that.

Dr Lambeth—I could not comment. I am certainly well aware that the risk increases. In this particular community, I do not have figures for that.

Mr Bromhead—I understand that in Queensland they keep a separate register. For us to develop a similar register that was unofficial would help give us the information on those linkages, but we do not have that type of unofficial register in place.

Senator HUMPHRIES—But there would be a number of suicides each year within the families of people who have previously suicided—would it be as large a number as that?

Dr Lambeth—We would expect there to be some. I think the figures are too small to enable me to make the judgment that it would occur each year.

Mr Bromhead—At a policy level, one of the issues we are very cautious about is breaking up the number of 31 too finely, because very quickly the information becomes identified rather than de-identified, if you know what I mean. Within the ACT—

CHAIR—Because their numbers are so few.

Mr Bromhead—Our numbers are so few. We could ask various elements, for example, to research back over a longer period of time through the National Coroners Information System and ACT-specific information. That may help us.

Senator HUMPHRIES—You made some comments about some confusion about the National Suicide Prevention Strategy, exactly what the strategy is and which document it is. Given the nature of the strategy that the ACT is pursuing, how does that manifest itself as a problem or concern for the way in which you roll out your strategy here?

Mr Bromhead—In fairness, we have used the LIFE framework as the foundation—the template—for how we have developed ours. While we have noted it, to a degree, as a difficulty, we have acted as though the LIFE framework is the national strategy. The technical difference is that it is a document of DoHA at the moment. I understand that it is not the endorsed national strategy currently because of the processes of going through Australian health ministers for the official sign-off. I am not sure where it is on that policy journey.

CHAIR—I have a specific question about the framework. We had the Psychotherapy and Counselling Federation of Australia in this morning, and they were suggesting that the LIFE framework is out of date already. It was developed in the year 2000, and they are saying they think it already needs a thorough review; it is 10 years down the track. You sound like you have used the LIFE framework as the foundation and built on it.

Mr Bromhead—We did not use the 2000 document; we used the 2007 or 2008 document—there is an updated version.

CHAIR—You have used the updated version?

Mr Bromhead—Yes.

CHAIR—Maybe that witness has not looked at the 2007 document, but there was definite evidence this morning that PACFA thought the document was out of date already. So, you feel that the 2007 framework is fine? Well, not fine, but—

Mr Bromhead—It was very suitable as a foundation for us to build upon. We also support a nationally consistent approach, for a variety of reasons, including so that we can end up knowing nationally what works and what does not work.

Senator HUMPHRIES—I just want to quickly ask you about prisoners. You said that you assess each prisoner for a mental health problem, and they either do or do not have a mental illness; if you are not certain, you do a further examination. At the end of that process, what proportion of ACT prisoners do you determine have a mental illness or dysfunction?

Dr Lambeth—At the moment I think that the proportion is somewhere around 10 per cent requiring clinical management. These are the more serious mental illnesses. We have quite a number of others who have difficulties in adjusting to prison and who have less serious mental illness; we do not necessarily allocate them for clinical management but they will perhaps be seen regularly by a doctor such as myself. They may have counselling with our psychologist, but they are not seen as someone requiring complete case management. So about 10 per cent of the prisoners have serious illness. Certainly, in line with most other jurisdictions, those who have some form of mental health problem are up around 70 to 80 per cent.

Senator HUMPHRIES—That is the figure that I have heard before, so that would be consistent. We were told in another submission that there is a particular vulnerability for people post imprisonment. Is there any follow-through in the ACT for people who leave prison? I suppose we are still in the early stages of our prison, but is it planned that there will be follow-up for prisoners who are leaving imprisonment and have had an identified mental illness issue?

Dr Lambeth—Yes, at the moment we have a seven-day follow-up procedure for those who are being clinically managed. That leaves a number of people outside that group, but a number of those may be managed by our Forensic Community Outreach Service, either alone or jointly with one of the ordinary community mental health services. The arrangement is usually made for people who do not fit into our service to be referred to a general practitioner—and you would understand that that can be difficult in the ACT with the shortage of general practitioners—or referred if necessary for psychological counselling or to one of the variety of other services that are present. So we basically try to ensure that everyone who has any mental health problem has some form of ongoing care. But naturally the most intensive ongoing care is provided to those who require case management.

Mr Bromhead—In addition to the clinical service, in last year’s budget the ACT government funded the St Vincent de Paul Society through Samaritan House to provide supported accommodation options, both short- and long-term, for people exiting detention. We made it a little bit broader because, in addition to the current prison, the ACT government is committed to building a secure in-patient unit for people with severe mental illness. They will also require this more specialised psychosocial support on exiting that place, and for many of them—not 100 per cent, but many of them—it will be a place of detention as well. People are also detained under the Mental Health Act—civilian detention—in the PSU, so they would also be able to access this particular support package. We have also talked with St Vincent de Paul, because they get people referred from other places to their particular Samaritan House centre who have been refugees and may have experienced immigration detention either in Australia or overseas as part of their journey to Australia. That is why we defined it as ‘detention’ and did not make it specific to the AMC. But we have been talking with them. We have said we expect that there is a priority to the AMC and to the secure unit when it is built.

Senator HUMPHRIES—I realise I am taking a lot of time, but I have one other question.

CHAIR—That is fine. It is your area.

Senator HUMPHRIES—On the question of prisoners, someone who has been imprisoned because of a crime they have committed is identified as suffering a substance abuse problem, is that generally classified as a form of mental illness? Bodies like the AMA do make that connection. What is your classification?

Dr Lambeth—Of itself, without any other evidence of mental illness, no. Almost invariably there is other evidence but the substance abuse is treated by the alcohol and drug group with us looking at the mental health side of it.

CHAIR—So they would get support on both sides.

Dr Lambeth—That is right.

Mr Bromhead—Yes. I am not an expert to talk about the AMC but the AMC has a drug and alcohol—

Senator HUMPHRIES—This is the jail?

Mr Bromhead—Yes. It has a drug and alcohol therapeutic community that is inside of it as part of attempts to deal with this problem. I cannot talk much further beyond that because I do not have a great deal of the detail about it. It is contracted by ACT Health with one of the major AOD community sector providers.

Dr Lambeth—And we provide joint clinical management so that there is a fair bit of discussion that goes on between the mental health and the alcohol and drug side of things as to what is the best management for people.

Senator HUMPHRIES—I assume that the AMC is compliant with the standard set by the Royal Commission into Aboriginal Deaths in Custody so that there are certain standards about the potential for suicide to be carried out inside the prison. Have there been any attempted or successful suicides in the facility since it was opened?

Dr Lambeth—There have been no successful suicides. There have been episodes of self-harm and there would probably be some debate over each as to whether it was actually an attempted suicide or not. I think some are unlikely to be an attempted suicide and are more of an expression of frustration or whatever and self-harm. For example, someone swallowed a screw, which caused quite severe internal damage. I do not believe that was an attempted suicide but it was certainly self-harm.

Senator HUMPHRIES—Are figures about those sorts of things published in annual reports about the prison?

Dr Lambeth—They certainly will be. We are at present undertaking a research project to look at the mental health issues in the prison—the incidents, what is required, all of the factors associated with it.

Senator HUMPHRIES—The Step Up/Step Down facility: how many beds does that have?

Mr Bromhead—The ACT has two Step Up/Step Down facilities. One is a youth one and the age range is from 13 to 17.

Senator HUMPHRIES—Where is that?

Mr Bromhead—It is at Watson, on the old Watson hostel site where Ted Noffs runs a youth drug and alcohol residential program as well.

CHAIR—How many beds was that?

Mr Bromhead—It is currently a five-bedroom facility. It is a partnership between Mental Health ACT—the public mental health service—and Catholic Care, as the community sector provider. The partnership is that Mental Health ACT currently has a clinician on the site 40 hours a week and Catholic Care manages the day-to-day management and activity and psychosocial support for those young people. A similar model operates in North Lyneham for the adults aged 18 to 64. It is also a five-bed unit. At the moment the psychosocial support and day-to-day management are undertaken by Mental Illness Fellowship Victoria and they also have an on-site clinician 40 hours a week from Mental Health ACT.

Senator HUMPHRIES—Lastly, was it the IMPACT program which you said had been inherited from the previous ACT government and that was still rolling?

Mr Bromhead—OzHelp was an initiative under the previous government. It has continued to be supported with increased funding to it through the current government.

Senator HUMPHRIES—Thank you very much.

CHAIR—Senator Moore.

Senator MOORE—Gary, did you want to follow up on the cross-border stuff?

Senator HUMPHRIES—Yes, actually—sorry. I would not mind.

Senator MOORE—Because I knew you had an interest in that from the past—so it is cool for you to do that.

Senator HUMPHRIES—Thank you, Senator Moore. The first witnesses we had today talked about the problems with mental health workers being able to follow patients who had reason to be, in this case, on both sides of the New South Wales-ACT border. They made the point that a particular patient, who subsequently suicided, originally lived in Queanbeyan but wanted to have their own flat in Canberra, and the mental health worker had to change when they crossed over to live in Canberra for a period of time. There was lots of crossing backwards and forwards. Is there any funding or any sort of protocol that prevents a caseworker being assigned to that person irrespective of which side of the border they might live on?

Mr Bromhead—There are two difficulties here. One is that the states and territories wholly fund the community mental health clinical services. You come back to the problem of ratepayers supporting each side of the border. Since—

Senator HUMPHRIES—But, just to butt in there, people who cross the border from New South Wales for medical services can be provided with those services in the ACT, and of course there are cross-border payments under the Grants Commission to cover those costs. So why can’t we treat a person who crosses the border for mental health services in the same way, and assign them a mental health worker irrespective of where they actually live?

Mr Bromhead—I will answer with the second part of the problem, which is that there is a historic problem—that is, that the mental health acts stop at the borders because they are jurisdiction based, and the funding issues have aligned with the mental health acts to a degree. It is a historic problem. There are occasions where, for somebody who is moving backwards and forwards across the border, handover periods and follow-up can be maintained as long as the clinician is registered in both states. So there is a registration issue—which I understand may not be as much of an issue once national registration is in place. There is some degree of that problem around the follow-up. So it has largely been a historic thing and largely been around how the services are funded and structured according to the funding.

CHAIR—I am wondering how many people would be in this situation: this particular person had to have a caseworker in the ACT and a different caseworker in Queanbeyan, and it seemed crazy to have the system split like that when continuity of care is an issue that has been brought up time and time again. Are there other people that would be in a similar situation, do you think, and is it ongoing? That was in 2003.

Mr Bromhead—I will have to leave the ongoing issue to Dr Lambeth. I am not currently in the service.

Dr Lambeth—I have certainly not been made aware of any issues concerning this since I have been in my current position, but that is only a number of months. I agree that, if that were the case, it would be a problem. We would need to look at the memoranda of understanding between the territory and the states and we would need to look at the mental health acts to see just what could be offered within the limits, particularly of the acts. But I am sorry; I do not have any figures on that.

CHAIR—I want to follow up one particular issue. Because of the small size of the Territory, you may not be able to answer this, but when we were in Queensland we had the Commissioner for Children appear before us, and they have done a very comprehensive analysis of their number of child deaths and looked at the number of suicides. We have found in some jurisdictions that there does not seem to have been a close look at the figures for child suicides. Is that an issue in the ACT and have you broken down and looked at your figures? I realise that because you are a small centre you may not have been able to and it may not be an issue, but it seems to be coming up in a couple of places as not being adequately dealt with. Have you looked at that issue?

Dr Lambeth—No, not specifically, but a breakdown of the figures, for example, in 2007, which I do have, does not show child death by suicide. It is something that was actually brought up to me yesterday when I was training people on assessing suicidality and it is something that I have noted down that we need to look at. Whether there are any child suicides in the ACT or not, I do not know. The information I have does not bear that out, but we will be looking at it.

CHAIR—If you could provide us with any information on that on notice, that would be appreciated. We have been following it up in each of the states that we go to. As I understand it, Queensland now individually follows up each case.

Mr Bromhead—Just for definition for when we go and do a little bit of research, what is the age range that you are talking about?

CHAIR—Eight and above.

Mr Bromhead—So, eight to 12, eight to 15, eight to 18?

Senator MOORE—We will get that to you, Mr Bromhead, as to what the Queensland figures are. The information seemed to be that they were the only ones doing it in that degree of detail. It is part of this whole trying to bring all the data and all the assessments to one level. We did get the information in Queensland, so we will get that to you.

Mr Bromhead—Thank you very much.

CHAIR—Yes, we will get the information to you and if you could provide us with any feedback, that would be appreciated. So we have given you a little bit of homework. Thank you very much for your time.

Proceedings suspended from 12.17 pm to 1.33 pm

CHADWICK, Ms Sharlene, Training and Development Manager, Peer Support Australia

CHAIR—Welcome, Ms Chadwick. Thank you for presenting evidence to the committee today. I understand you have been given information on parliamentary privilege and on the protection of witnesses and evidence.

Ms Chadwick—That is correct.

CHAIR—We have your submission. Would you like to make an opening statement? We will then ask you some questions.

Ms Chadwick—Thank you. I will make a short statement. Peer Support Australia is a small not-for-profit non-government organisation and, in the nature of small, we comprise six staff. Three of those staff conduct all of the training and development across the areas that we work in.

The Peer Support Program is a peer led, universal program which has been operating in both primary and secondary schools for almost 40 years. It is skills based and experiential and it emphasises developing skills for enhancing lifelong learning. It is integrated into curricula and it also supports a number of national educational initiatives.

Peer Support Australia has been successful in completing two projects since 2007 as part of the National Suicide Prevention Strategy with funding from Department of Health and Ageing. This recognises that the Peer Support Program has a positive impact on the mental health, resilience and connectedness of young people and acknowledges the development of skills through the program to build protective factors.

Universal interventions are at the forefront of suicide prevention initiatives. The Department of Health and Ageing has recently approved a third project as part of the National Suicide Prevention Strategy. This project will continue the work, predominantly Queensland, Tasmania, Western Australia and Northern Territory, through to June 2011.

The Peer Support Program identifies a range of key protective factors which help to maintain mental, physical and social wellbeing, which may reduce suicide ideation amongst young people. Some of these protective factors are social, such as interpersonal relationships or family cohesion, but a number of them are skills based, such as the development of empathy, resilience, assertiveness, decision making and monitoring stress levels.

In the recent research that we have undertaken as part of the Department of Health and Ageing project, we have developed an evaluation package that has allowed us to evaluate schools as a whole over time and also students where we believe that students do develop these skills over a period of time. The Peer Support Program is a valuable learning experience for students, and, in conjunction with a range of other strategies, is actually a powerful tool for bringing about cultural change in schools.

Finally, the program currently operates in over 14,000 schools in New South Wales, the ACT, Queensland, Tasmania, Western Australia and the Northern Territory. Thank you.

Senator MOORE—Ms Chadwick, how do schools get involved with your program?

Ms Chadwick—Schools get involved with the program in a number of ways. Because we have been operating for almost 40 years in New South Wales, we are now finding that teachers in schools were peer support leaders when they were students themselves. So it is past experience with the program that attracts them to having it operate in their schools. However, in the last handful of years, we are expanding into unknown territories and newer markets where the program is not as well known. So we do a lot of awareness raising and profile raising in going out to these areas—because we are based in Sydney—travelling to these areas, meeting with key people in education and health, and meeting with principals and teachers to explain what the program is around and the benefits of the program. Then, from that point, schools are able to attend training and professional development in our program. They are then able to purchase resources that the students facilitate.

Senator MOORE—In your evidence and your submission you talked about the fact that health and ageing have now funded you to expand.

Ms Chadwick—Yes.

Senator MOORE—Is it an expensive program?

Ms Chadwick—We believe we offer it under a highly leverage model. That is why we have three and a half staff who conduct all of the training and professional development across the country. We bring in 15 or 20 teachers from a range of different schools to centralised locations where one of us will facilitate a days worth of training. Those teachers will then go back and work with their staff who will then work with the students. So, from that highly leveraged model, the costs are: teacher relief, physically getting us around the country and the development of the resources to make sure that it is in line with current research, teaching practice, national agendas and the national curriculum that is coming through. So it is the developmental process that takes quite a lot of our time and funding, to make sure we are providing the best possible program for young people meeting today’s needs.

Senator MOORE—So, in terms of the outside impact, it is only the cost of your professionals who are going out. Once it is established in schools they could continue to self-run?

Ms Chadwick—They can continue to self-run. We have a requirement where we really encourage schools to retrain somebody within their school community every five years. In that time we have probably reviewed and evaluated some of our learning modules. In that time more evidence or more research might be available and it just keeps the program dynamic, which is the success of it.

Senator MOORE—Do you operate in both primary and secondary schools?

Ms Chadwick—Yes, we do run in both.

Senator MOORE—Once you have trained the people and they have the necessary skills base needed to go back and work within their school environment, how much time and resource is taken within the school itself?

Ms Chadwick—Initially there is a two-day leadership training—and we will talk specifically around New South Wales because it is easier than switching backwards and forwards—so year 6 are trained over two days to lead the sessions in primary school. Year 10 are trained over two days in secondary. So it is two days of training, then it is a commitment of at least eight weeks, or one term, to run the program. That is about 30 minutes a week. There is also support from peer leaders in terms of briefing and preparation which could be an extra half an hour each week.

However, in terms of the structure of the program we really only recommend that schools run it for one term. What we then develop in schools is this notion of what we call a peer support approach. It really demonstrates to us that protective factors are developed in more informal structures and so it is developing those positive relationship and support networks beyond the structure of the Peer Support Program yet still using those peer leaders to facilitate a range of other initiatives that most schools have in place.

Senator MOORE—In your submission you make reference to three evaluation processes that you have undertaken following the training of key people in a range of schools over the period. Given that evaluation, what is the maintenance record of the schools? Is there much of a dropout?

Ms Chadwick—Particularly in the areas that we have started to expand into, in Western Australia and the Northern Territory in particular, there is a high turnover of staff in those rural and remote areas. Some staff change completely within a calendar year. That makes the sustainability of the program quite difficult and therefore we recognise that we do need to be servicing those schools and building that capacity on an annual basis because of that. However, we do have a tracking system with our electronic records where we can now start to track teachers. Teachers move, not only from school to school but from state to state, and we are endeavouring to try and track those teachers, because a lot of the time teachers will take the program with them to new schools but do not always let us know that. So it is difficult for us to get an absolute on the number of schools that are running the Peer Support Program, but we are working on current training, current resources and current membership to give us that figure that we quoted earlier on.

Senator MOORE—So with the expansion that you are now talking about, is there an evaluation process engaged in each of those contracts?

Ms Chadwick—Absolutely. We have appointed an external researcher and he has worked with us for the last almost three years to develop a unique evaluation package for Peer Support Australia which provides schools a snapshot of before and after in terms of the culture of the school, the skill development and the skills base of the students. It also provides a reporting mechanism back to the Department of Health and Ageing. Following the two projects completed since 2007 we have submitted two comprehensive evaluation reports to the Department of Health and Ageing on the evaluation of those schools and the expansion to date.

Senator MOORE—Thank you.

Senator HUMPHRIES—I noticed reference in your submission to the Wellbeing Australia Advisory Group. Can you tell us a little about the organisation? How does it support organisations like yours?

Ms Chadwick—The Wellbeing Australia Advisory Group is also based in Sydney and is made up of a number of key educators, academics and organisations that work across the country to promote wellbeing initiatives which are based on evidence based programs. Professor Sue Roffey from the University of Western Sydney is the leader in that organisation. We have Dr Toni Noble as part of that organisation. There is also Marie Stanley from the Alannah and Madeline Foundation, which is linked to the National Centre Against Bullying. There are a range of people we meet a couple of times a year to talk about initiatives, practices and research to further the wellbeing of young people across Australia, particularly in schools.

Senator HUMPHRIES—It is a committee made up of organisations who come together, discuss these issues and share information?

Ms Chadwick—Absolutely.

Senator HUMPHRIES—Can you tell me a little bit about the National Centre Against Bullying too, please?

Ms Chadwick—The national centre for anti-bullying evolved from the Alannah and Madeline Foundation. The Alannah and Madeline Foundation was set up as a direct result of the Port Arthur massacre. Alannah and Madeline Mikac were Walter Mikac’s children, who were unfortunately murdered in that event. He set up a foundation not only to honour the memory of his children but to support young people who were on the receiving end of violence or crime. From that spun out the National Centre Against Bullying, because there was a recognition that violence is one aspect but, stripping it back further, bullying behaviours occur more frequently in schools than outright violent behaviours. So they are quite strongly linked. The National Centre Against Bullying runs a national conference every 18 months where key people report on and present evidence and research, and we have formed a partnership with the Alannah and Madeline Foundation. They have presented at that conference on a number of occasions.

Senator HUMPHRIES—Again, I take it that is a federation of organisations dealing in these areas which share information?

Ms Chadwick—Yes.

Senator HUMPHRIES—What does your organisation attribute the fall in the rate of suicides since 1997 to?

Ms Chadwick—Our organisation attributes that to the fact that there are a number of effective intervention programs that work in school communities in particular, because that is the basis of where we work. It is looking at a whole school approach where we are encouraging all members of the school community to look at the enhancement and development of skills around these protective factors. Protective factors have been recognised and are something that we firmly believe in. Rather than looking at what the risk factors are, we look at what protective factors are to support young people in particular.

The Peer Support Program also provides those support networks. The Peer Support Program is probably useful to mention. It started as a direct result of a youth suicide in 1972 in Sydney on the northern beaches. The health educator working in those schools at the time was asked to come in and do grief counselling with the students and she realised that they already had some form of support network. The young people were talking to each other and some of this particular student’s friends knew that he was struggling. So she developed the model of the Peer Support Program. Our history is such that we have been supporting young people in finding a structure and a forum where they can discuss and talk about how they are feeling around certain issues and then also have that link to school around who are the best people in our school community that we can go to and talk to and who can support us further. It may be teachers looking beyond the school at other agencies to support the particular needs of some students at risk.

Senator HUMPHRIES—Thank you very much.

CHAIR—Can I go into a little bit about how the program operates. How do you select the students who will be trained and then go on to work in the program with the other students?

Ms Chadwick—Essentially the school makes those determinations. Schools are best placed to know their particular students and the needs of their students. However, generally all of year 6 are trained and all of year 10 are trained. We believe that the two-day leadership training provides a range of skills which students need for lifelong learning and particularly for being able to progress through that confluence of adolescence issues regardless of whether they become a peer support leader.

Schools can then go through a range of different ways to select appropriate students to be leaders. Generally speaking again, in primary schools most year 6 students undertake the role of peer support leader because we need them all to. The ratio is two leaders to every eight or 10 students, split up vertically across the primary sector. In secondary there is an application process we encourage schools to do. Some schools will select students based on previous experience, how they relate to their peers, their ability to communicate effectively—those sorts of issues as well.

CHAIR—I would like to move on. How effective is it in Aboriginal communities or where you have a large number of Aboriginal students in a school? How many programs do you have running regionally or remotely?

Ms Chadwick—Over the last two or three years we have started to investigate the claim that we make that the Peer Support Program is a universal program. We have not really had evidence to back up the fact that it can be positioned into any school or any community and the outcomes will be much the same. Having said that, some of our anecdotal evidence in New South Wales over 40 years is that the program has worked in high Indigenous populations throughout regional New South Wales and also in the inner west of Sydney in particular. We were approached by the Department of Health and Ageing in 2007 for expansion predominately into the Northern Territory and the Kimberley because of their high Aboriginal populations.

From the preliminary pilot studies that we have conducted over the last 12 months we can see that the program is universal. By the end of June this year we will have conducted 18 workshops across rural and remote Australia, particularly in the Northern Territory. In fact one of my consultants is in Darwin this week running workshops up there again. What we are now starting to find from the evaluations and the surveys that are coming back from some of those areas is that the model of the program works and is successful. Sometimes it is the content of the materials we provide; we may need to look beyond this particular funded project, beyond June 2011, to start developing some of our written materials. Unfortunately we are very literacy based, and for some populations that is not a buy-in. So we need to find other ways.

CHAIR—Are you going to need further funding to look at the content of the written materials beyond the current program or is it something that you can deal with within your current funding?

Ms Chadwick—We are definitely going to need additional funding to do that. It essentially takes us a good 12 months to produce one eight-session module for primary school. That would be an approach where we consult with key stakeholders and teachers and they review our material and we also trial all of our activities with a range of students. That takes time for us to do. But what we are most conscious of is it being a sustained program where we do not come in and run just a handful of workshops over a 12-month period and are never seen again. We would like to maintain capacity building in going back into those schools or those school communities and running additional workshops over the next however many years. So it is not just about resource development; it is about ongoing funding to make sure that we continue the coordinated and more planned approach that we have had for a number of years in these areas.

CHAIR—I notice that you are not in South Australia or Victoria. What are the reasons for that?

Ms Chadwick—We have been asked this question! There are political reasons. It is political from the base that Victoria was an offshoot of the New South Wales Peer Support Foundation and South Australia was also an offshoot of what began in New South Wales. Yet South Australia come under the auspices of their education department and they do not have a foundation as such; they have teachers who are seconded from school to run workshops. So we do not work in South Australia at the moment.

There is some significant history between our organisation and Victoria’s, and at the moment we do not work in Victoria. We come under the auspices of a board of directors and they will make the determination in the next couple of years about whether we start to operate our particular Peer Support Program in Victoria as opposed to the current organisation in Victoria that runs their own version of the Peer Support Program.

CHAIR—So there is an organisation running a peer support program, but it is not your program?

Ms Chadwick—That is correct.

CHAIR—Is that the same in South Australia?

Ms Chadwick—Yes, that is correct. It is the same in South Australia.

CHAIR—There is a peer support program running in South Australia as well?

Ms Chadwick—Yes, that is correct.

Senator MOORE—Is it similar, Ms Chadwick?

Ms Chadwick—It all branches from the same model, where—

Senator MOORE—So there is some commonality.

Ms Chadwick—The model is exactly the same. The principles are the same. It is how we go about doing it that differs. Essentially we have a team of three that work with teachers. The Victorian model, I know, is that they actually go into schools and work with students. That is essentially how it differs. They run the Peer Support Program in Victoria but they also have a range of other programs, whereas we have the Peer Support Program with a range of different modules. So we only focus on the Peer Support Program, whereas Victoria focus on about eight different programs of which the Peer Support Program is one.

CHAIR—You think that the more focused approach you take is a better approach?

Ms Chadwick—Absolutely. We have had evidence from a longitudinal study from the University of Western Sydney, from case studies from James Cook University, from a pilot study from Deakin University and, over the last two years, through the pilot study with the Department of Health and Ageing. These studies provide the evidence of what we have come to know, anecdotally, over the preceding 30 years.

CHAIR—Do you work with other organisations in schools? I will give you an example. In Western Australia, we have an organisation called Youth Focus who, as the name suggests, work with young people on suicide and mental health issues. They do some work in schools and are keen, I understand, to do more work in schools. Would you work with an organisation like that in schools or do you work totally separately from other organisations doing work in schools?

Ms Chadwick—We tend to work separately from other organisations, and that is due to funding. If there were opportunities and funding available for us to form partnerships with other organisations that had values and philosophies similar to what we are trying to achieve, then we would not be averse to that in particular.

CHAIR—You may have touched on this before and I missed it. How do you let schools know what you do? You have got 1,400 schools across Australia—that is right, isn’t it?

Ms Chadwick—Yes.

CHAIR—How do you contact schools? Is it outreach by you or do you wait for a school or teachers to come to you?

Ms Chadwick—It happens both ways. We cannot possibly contact every single school that does not run the program. There are 3,000 schools in New South Wales alone and about 10,000 schools in the country, I believe. We have a website. We have an e-newsletter that we send out to all schools. We promote workshops and the work that we do at the beginning of each term. We present at conferences. We have developed research papers ourselves. We try and get into local media to advertise local aspects of what the program does, because those are the stories that are really important to schools. Our training is endorsed by the NSW Institute of Teachers. The Peer Support Program is actually endorsed as part of the Western Australian Certificate of Education now. Those sorts of things might be considered a ripple effect. Sometimes parents will contact us and say, ‘I have heard about your program. How do I get it into my school?’ We might do presentations for Catholic schools, independent schools, parent meetings, parent forums—a whole range of different things.

CHAIR—Thank you. I am sorry, but I am going to flick back to the issue I asked about before: programs for Indigenous students. You said you would require further funding for developing the new content. Are you working on applications? What is your next step in developing that area?

Ms Chadwick—What we are doing at the moment is running these projects through to fruition in June of next year. That is to get a lot more evaluation on what is working and what can be improved in schools. From that point we will then look at what we might need to develop. What we have already determined—and this may happen in the next financial year—is that we believe we need to develop a working title of an advisory group of teachers and bring them to Sydney from locations such as the Kimberley, the Northern Territory, Perth, Queensland and Tasmania and actually talk with some of those teachers who have said to us just casually at workshops or over the phone in the last eight months, ‘The model is great, but we had to adjust some of the sessions.’ We do not quite know what it is that is not working until we bring them together, have a forum and talk about what it is that we might need to do. That will give us directions forward, we hope.

CHAIR—Thank you. You have given us very comprehensive answers to our questions. Thank you for your time in appearing and for your submission. It is much appreciated.

Ms Chadwick—Thank you very much for your time as well.

[2.02 pm]

DELAMOTHE, Ms Katrina Joan, Adviser, Access to Allied Psychological Services, Australian General Practice Network

WELLS, Ms Leanne, Executive Director, Policy and Business Development, Australian General Practice Network

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

Ms Delamothe—I am a clinical psychologist and service manager of mental health programs at GP Access, also known as the Hunter Urban Division of General Practice.

CHAIR—Thank you very much. Have you been given information on parliamentary privilege and the protection of witnesses and evidence?

Ms Wells—Yes.

CHAIR—Thank you for agreeing to start a bit earlier. We have your submission. I invite either or both of you to make an opening statement, and then we will ask you some questions.

Ms Wells—I might start by talking very briefly about the role of the Australian General Practice Network. We are the peak body for the divisions of general practice network. We have a membership of 110 regional organisations and eight state based entities. The membership base of those is around 90 per cent GPs, but there is an increasing membership base of practice nurses, GP registrars, practice staff and allied health professionals. I think the key point, the noteworthy point, about the network and the infrastructure it represents is that, given the relationship between mental health problems and disorders and suicide and suicide prevention, general practice networks are very active in mental health care programs and service delivery and suicide prevention programs and service delivery and are experienced in community engagement and community capacity building.

Our submission was not extensive but we really focused it on the terms of reference that were relevant to our core business: those issues to do with the role of agencies—in our case, the general practice networks—suicide prevention training and targeted programs, which we made some comments on and some recommendations around.

I guess at the outset we would say that we are strong supporters of the National Suicide Prevention Strategy, the LIFE framework, and its design around universal selected and indicated interventions. Suicide is a major national public health priority that warrants a national policy framework. The effectiveness of such a framework really is a product of the resources and capacity that are directed towards action under a framework like that and any associated evaluation, of course, that determines whether the strategies in a document such as that are the right ones to back.

Our key points today are to emphasise the role of general practice as a setting and the role of targeted programs available regionally through divisions. I think there is probably no doubt that general practice is a key setting where suicide risk factors are identified. There is a window of opportunity there. People visit their GPs quite commonly. A GP is often the last clinician to see a person before they attempt suicide. The other key point, given the strong relationship between suicide prevention behaviour and mental illness and mental disorder, is that it is that front line primary care setting where high-prevalence mental health disorders are managed.

We have had a number of successful programs running through the network addressing that area. We run a program called the Access to Allied Psychological Services program, commonly known as ATAPS. Our members have been involved in running an innovative new service model called headspace, which is a multidisciplinary and intersectoral response to youth mental health through service hubs. I think we can demonstrate—and Katrina might comment on this one in particular—that the ATAPS service has been a very potent platform for filling service gaps, providing access to free, if not highly subsidised, mental health care to people who would otherwise not have been able to access services. It has recently incorporated a suicide prevention service pilot, and Katrina will talk a bit about that.

The only other comment I would make is that the divisions are well placed to respond in a very targeted way to crises in communities. We have had about 43 divisions very actively involved in the Mental Health Support for Drought Affected Communities Initiative, which has involved a lot of community outreach, crisis support and promoting mental health literacy in community type activities. Probably most recently, the Victorian divisions—I think there were about nine Victorian divisions—in the regions affected by the Victorian bushfires received quite a lot of supplementary funding through the ATAPS program to provide a targeted psychological response to families affected by the bushfires. Of course, the risk of suicide would have been a key concern in that context. I might leave it there and hand to my colleague.

Ms Delamothe—I am coming from the perspective of working in a division of general practice for about five years. It has a mix of regional and rural demographics, being around Newcastle and certainly the rural areas surrounding that. There is a population of about half a million and about 400 GPs. Our division has been particularly active in running most of the newer federally funded mental health programs—some of the examples that Leanne mentioned, like ATAPS. We are also funded under part of the Perinatal Depression Initiative, the suicide and self-harm project, and we also have experience from our flood emergency effort of nearly three years ago now.

For us it has been a really interesting time as what we call the primary mental health care sector emerges, develops and moves into a space that, I think, has been previously fairly underoccupied. That space is the one where GPs are referring large numbers of patients, first of all with general mental health difficulties and then also, as we move into some of the other programs, with some more specific difficulties. It has become apparent to us that there are some patients who can be managed very adequately in general practice and that is the level of intervention that they need and there are a few people, generally and specifically, who need acute services and hospital care as provided by our state health services. But GPs will say and have said to us that the large majority of presentations for mental health problems actually are not served by those two ends of the spectrum and it is the larger part of the bell curve that we are really seeing the patients from.

If we talk more specifically about how this applies to those people presenting with suicide and self-harm, we believe the services orientated to general practice have been really successful, because there is a lot, as we say, between ‘monitor’ and ‘admit’, and there have actually been very, very few services. The vast majority of these patients need management in the community, and that is where there has been a paucity. I think programs such as Better Access and Better Outcomes in Mental Health Care, although not perfect yet, certainly have begun to make a really good start in filling the gap in provision of general mental health services. I think that the models that are starting to respond to suicide and self-harm—for example, the suicide and self-harm pilots, some of the Lifeline postvention work and headspace—have been really important. The main tenets of those services are that they need to be responsive, so they see people quickly; they are flexible, so they can offer a range of options depending on the person’s need; and then they are accessible, both geographically and economically.

We believe that they need to be run by primary care organisations. I have worked across sectors. I have worked in state health in primary care and private practice. It would seem that the organisations that run those services best are those that have some understanding of and alignment to general practice rather than sitting in some other sector. I think this is to prevent some of the gaps that we have identified. It seems to be, certainly in New South Wales, the only way to get really good coordination and continuity between services. That is probably all I would say upfront, but I am happy to answer any questions from anyone.

Senator MOORE—I am really interested in the ATAPS program and the one that is specifically focused on suicide. We spoke with Crisis Support Services this morning about their part of it, which is that when they have been contacted by someone they can actually focus and refocus with that person. From the perspective of the GP network, have you had any feedback from those people about how effectively they think this focus program, with call back linked in with a service provider, is going?

Ms Delamothe—I cannot make too many comments because it is not a service that we have actually used very much.

CHAIR—I think they are been trialling it in Victoria at the moment.

Senator MOORE—From the national level, have the people in Victoria given any feedback?

Ms Wells—We have not had any feedback about—

Senator MOORE—There are a number of your divisions of general practice which are involved in that, are there not?

Ms Wells—Just to clarify, you are asking about the suicide pilot through ATAPS?

Senator MOORE—Yes.

Ms Wells—Yes, there are 19 divisions nationally involved in that. I am not entirely clear on how the CSS service model fits into that.

CHAIR—We might be talking at two different purposes here. In terms of the ATAPS models that you are talking about—because we got evidence this morning around a specific program, the trial, that is running out of CSS, doing call back and after-hours call back, and they are like the supplementary service for when—

Senator MOORE—Which they said was linked in with the one with the doctors. It was an expanded process that you had—

Ms Wells—It was a supporting service, yes, to the standard.

Senator MOORE—'All part of the one file' was how they described it to us.

Ms Wells—We have not any specific feedback about how useful or not that service has been, but we can very quickly get a rapid response through our members, if you would like some perspectives on that.

CHAIR—That would be very much appreciated. When you are talking about the ATAPS trial we know there is another trial that is going to be operating in Queensland. That is right, isn't it?

Senator MOORE—There is one existing in Queensland that the Sunshine Coast division of general practice has been running for a while now, with one of the mental health programs.

CHAIR—I am actually thinking of a different trial. I am thinking of when they are released, which I think would be part of it. When they are released from hospital—

Ms Wells—That is part of the model, I think.

CHAIR—Okay, if you could tell us the model, that would be good.

Ms Wells—Katrina can talk to you about they are implementing the broad model in the Newcastle region. Divisions would be implementing it in very different ways. The idea was that we had an existing primary healthcare based psychological service called ATAPS. That had a very robust interface with general practice and an established referral pathway. For all the reasons we just talked about, the government decided to provide 19 divisions with some supplementary funding to provide a rapid response service—within 24 to 72 hours, I think it is—to cohorts: those who are identified as having suicide risk factors by a GP or on discharge back into primary care from the acute sector. The idea was to hook them, in a fairly structured referral way, back into some psychological support and intervention through the ATAPS program.

Its implementation was accompanied by a range of other strategies to support it. For example, there was some targeted suicide prevention and early identification training offered to general practice and practice nurses at the primary end of the spectrum. There was some quite specialised training offered through the Australian Psychological Society to allied mental health clinicians working in divisions in the program. The University of Melbourne has been systematically evaluating ATAPS across the course of the program's life. I think we are up to about 14 documented evaluation reports of that program looking at factors like how well the system has changed, consumer outcomes and the profile of the patients that are coming through the system—as we said, high-prevalence disorders, care to people who were not otherwise accessing care in another system or through the private system, and people generally showing improvement in four to five visits. It is a rare program, really, in that it has had a good evaluation underpinning it.

The University of Melbourne has also been tracking and evaluating the ATAPS suicide pilot. It is pretty early days and I think it is very ambitious to get a pilot of that scale up and running. I think it was initially funded for about a nine-month period. As Katrina said earlier, when you are talking about working across systems and building a service that bridges that general practice and hospital divide, it takes a lot of negotiation and service design planning. I think uptake and inroads are very diverse across the 19 divisions, as would be my impression.

Certainly, there are some key points from the evaluation by the University of Melbourne. We can now see that services are beginning to steadily attract referrals from GPs and emergency departments. The profile of consumers is different to those who the general ATAPS, if I can call it that, is attracting. This suggests that the more specialised nature of these services is reaching the different group of consumers they were intended to reach—those at risk of suicide. Similar to ATAPS, that cohort of consumers is receiving free cost services with little or no co-payment. Close to half of the service users have low incomes. And at the system level, most divisions are reporting, from the feedback they are getting, positive impacts from referring to GPs and the relationships with the emergency sector.

I suppose the only observation I would have—and it is a response to the dreaded p-word, ‘pilot’—is that I think it is very tricky when you introduce a service like that as a pilot. That is because it generates a level of expectation by the community and general practice and hospitals that if it succeeds then it should be retained. Some more stability around the funding level into the future would, I think, provide GPs who are perhaps a little sceptical of the word ‘pilot’ with some more surety about referring to and utilising the service. Katrina might want to comment on their specific model of service and how they have integrated the suicide pilot into their ATAP service in Newcastle.

CHAIR—I would very much like to get a picture of how it physically works. It would be appreciated if you could give us some idea of that.

Ms Delamothe—Certainly, because that is exactly where I sit. As the developer and the manager of the service that is probably one of the largest in terms of the division-run services, I think the ability to add services such as the suicide and self-harm project and its success have sat on the platform of ATAPS that Leanne has referred to. That was divisions stepping in and setting up something that was absolutely suitable for their environment, be it metropolitan or regional or rural, and working with the organisations that existed in those places, which are greater or lesser depending on where you are, and with the availability of the workforce. We have evolved our model and so now we have staff completely employed by the division and they now work from three different geographical sites because access was something that GPs told us was a big issue, as was cost. So our services remain free to the patient, which does put some strain on us some of the time. That service is set up to see what we call ‘common presentations’ or high-prevalence disorders. About 80 per cent of our presentations are depression and anxiety in their various forms.

We have been running the clinical service for about three years. It took a while to get traction in GP-land because it is like, ‘Who are you and what do you know about this stuff, and how long are you going to be around? Is the funding to keep going? Who do we refer?’ There was a lot of work in, first of all, the GP training and then in GP engagement. We have now got really high engagement for a primary mental health service. In any given year about 70 per cent of our GPs refer one or more patients to us. It is on the back of that reputation that we have been able to then very easily add on. We got together the emergency response within three days. It is easy when you have got a platform rather than starting from scratch. Similarly, with the perinatal depression, it is relatively easy to add it on.

The GPs now have a really good understanding of the cohort of patients that we will see, which is the majority of patients who do not need acute or hospital services. When the suicide and self-harm project came along, there was no doubt in our division about taking that on, or at least tendering to take that on, because GPs for ages had been saying, ‘The group that we really struggle with are the people who have suicidal, self-harm ideation or behaviours,’ and most of them we cannot get in anywhere. The capacity of state health services is very limited, so you have to be at the really severe end or with enduring or chronic problems to get in and to be followed up by them. I know some divisions have had trouble getting GPs engaged, but we had no trouble at all and went to 80 per cent of our capacity within a few months. We have only been open since January 2009.

How does it work? I was just talking to a GP this morning and he uses the service quite a lot. It has moved from GPs or a practice staff member perhaps faxing us a referral. The GPs now ring up when they have got a person in front of them in the room—as they see it, as they identify it—and there will be someone at our end who will pick up the phone or be found to speak to that GP and make arrangements, right there, at the time, for an appointment or for a telephone consultation. We will do something appropriate. If it is appropriate and possible to do so, we arrange to speak to the person while they are still at the practice. I think the immediacy of it is really important, as is the fact that the GPs know that we will do something appropriate and relevant and we have got the right skill set to do it. Just as likely, if we see the person or if we assess them and think, ‘Hmm, maybe this person needs hospital treatment,’ we will also organise that and get that person to hospital.

We find in New South Wales that the one of the big divides is GPs and hospitals, so I suppose we are easing the pathway out of general practice to care, and to hospital for the very few who need it. Of a quick audit yesterday of the last 100 patients we have seen under the suicide and self-harm program, two required us to organise hospitalisation. So it is really a small number relatively, and this is the higher risk population that we are seeing straight out of general practice. There are some that the GPs will send straight to hospital and they will not even come near us. But it is also, they say, a rare event that they will do that. Likewise, the step down that Leanne was referring to out of hospital is actually not out of mental health hospitals. The suicide pilot has excluded us taking people who are or have recently been under the care of a state mental health service. The emergency departments and the hospitals that we must link in with—the three major hospitals in our area—are the ones that are responsible, in our case, for seeing all presentations with deliberate self-harm and self-poisoning, so it is a clinical toxicology, consultation, liaison and psychiatry service that covers ED for those people who actually do something and end up in hospital somehow or end up presenting to ED. Our service is the step down for those patients. Professor Greg Carter, who I know has put in a submission to this committee, is the person in charge of the psychiatry part of that service. I think there is room for us to move into taking patients from the mental health services where there is GP involvement or an identified GP, rather than where they go now, which is often into the ether. That is a really high risk area. Within 24 hours to 28 days from discharge is the high-risk area for people to actually complete suicide.

Senator MOORE—So what services do you provide? I am trying to work it out. The GP contacts you and the hospitals can contact you but—

Ms Delamothe—what do we do?

Senator MOORE—Yes.

Ms Delamothe—Our service is staffed at the moment by all psychologists, 19 psychologists—

Senator MOORE—19?

Ms Delamothe—Yes, 19. Half of them are clinical psychologist and all but two of the others are undertaking postgraduate clinical training, which we believe for quality and outcomes and effectiveness is really important. They do their clinical work in those three different locations.

Senator MOORE—So at the moment you are providing that free, so there is no Medicare payment?

Ms Delamothe—Free at point of patient contact, yes. What we have done, on demand from GPs, is a big diversification so, as well as our federally funded services, we are actually up to providing about 30 per cent of our total throughput by Medicare, totally bulk-billed. The GPs know the pathway in is the same. Whether it is better access or better outcomes the pathway is the GP mental health treatment plan. What the psychologists do is clinically appropriate and not dependent on what program they come under, although the programs are very similar in terms of limited sessions. I guess we have stepped into some of the areas that GPs say they are really unhappy about, which is about the communication and so we contact the GP at multiple points in that—

Senator MOORE—Keeping the link in with that.

Ms Delamothe—We have electronic encrypted messaging. So they know that we have got referral, they know when the patient's appointment is, they know after the first session what we think and they know if we want to change something. We also run a GP referral advice line so GPs and the practice staff can ring us at any point with any concern about anything to do with mental health and we will do something about that.

Senator MOORE—And this is all funded under ATAPS?

Ms Delamothe—Under ATAPS and the various other programs and Medicare, with suicide totally under ATAPS.

Senator MOORE—So the people that are referred to you are still subject as to the limited number of consultations that they can have?

Ms Delamothe—Are you referring to ATAPS or suicide?

Senator MOORE—ATAPS.

Ms Delamothe—Yes. Suicide is unlimited for two months by phone or face to face.

Senator MOORE—So we still have limits on it. What worries me—and has worried me from the beginning of this program—is that you have someone who has a service provided which was not there before. It is a major advantage. What happens when they come to the end of the allocation under whatever program? I think that is heading towards another cliff. We have a process in there now which I think is much better than what they had before but, because there are still caps on it, you would have someone who would just be becoming confident in being open and working with a practitioner but whose allocated visits then end. What happens then?

Ms Delamothe—I cannot tell you the number of ways that we have thought about that. That is challenging for a number of different reasons. With the suicide and self-harm program, which is unlimited sessions but over two months—it is time limited—those people can transfer to ATAPS because we also run that.

Senator MOORE—To get back into ATAPS do they have to go back to the GP and be referred on?

Ms Delamothe—People require a mental health treatment plan to get into either of those plans.

Senator MOORE—Can it be the same on?

Ms Delamothe—It can be a treatment plan that lasts for 12 months unless there has been any significant change in the condition, in which case they have to update.

Senator MOORE—So a GP can write a plan for someone who is suicidal or presents in that way. It would be a longer term plan which begins with the two-month interaction but could say that after discussion with the practitioner it could well be that they could transition into the other form without needing to go back and have another plan.

Ms Delamothe—Yes, but we would be very encouraging of people to visit the GP along the way. Certainly, if we are in theory discharging them from the suicide and taking them into ATAPS, even though it is seamless, there would be a discharge summary, communication and agreement with the GP on our plan of transitioning them for the slightly longer term care. If someone comes into ATAPS—and we know it is six plus six under most circumstances—I do not want my clinical staff to launch into seeing someone and head towards 12 sessions knowing from the patients we know that that is not going to be enough. So I say to them, ‘The earlier you know that this is not going to be the right model’—because we have now done some work on researching which patients this model is most suitable for. We will try to transition them early—as in two to four sessions—to another, appropriate service. We have been getting those links with some of the more specialist services for personality disorders, children and adolescent mental health, early psychosis and all sorts of other presentations. What I have been trying to do in that transition is say to the more specialist services: ‘We have seen them. We have assessed them. We’ve got a really good idea of what’s going on. If we can get a good liaison going and you can trust that judgement, there are a whole lot of other people that you won’t need to see, because we’ll see them and deal with them. You’ll never get to them.’

The links to state mental health services are challenging and interesting, but we keep chipping away at that. I think in primary mental health you can see a whole lot of the work that they would have been inappropriately referred previously because they were the only place the GPs could send people. Often I use my leverage with some of those services to say, ‘If we work together it’s actually going to be better for you and decrease your capacity rathe than increase.’

CHAIR—Will they fund you for that? How do you work that? If you go to the state services and say, ‘We think we’ve got somebody who should be accessing your services, but we think it’s better if we support them,’ do they then give you additional funding to do that?

Ms Delamothe—No.

CHAIR—Can you walk me through how you then do it? If they are going to need more treatment than the 12 and you have used up—

Ms Delamothe—No, we would be transitioning them if and when we get to know.

CHAIR—But you will not keep treating them.

Ms Delamothe—No.

CHAIR—They will go straight over to the other services.

Ms Delamothe—Yes. But getting them there once we have started is sometimes quite hard, because they are bursting at the seams.

CHAIR—That was my next question.

Ms Wells—So they say: ‘But can’t you keep treating them? You’ve got some expertise and you’ve started, and we’re full; can’t you just keep doing it?’ So there is tension around transitioning on. We are trying to use private practice a little bit more. The advent of Better Access has been a good thing, but they are also full. It is also now, in our area and in lots of areas, a two-tiered service, so you can go if you can pay but you cannot go if you cannot pay.

Senator MOORE—That would be my concern about some of the patients with whom you are working: that they have found, now, a service that is giving them support which is free, but you would just know that the next step is one some people are not going to take. You can, in good faith, say, ‘This is where you need to go next,’ but if there is a cost involved you must have an absolute knowledge inside that they are not going to pay and so are going to drop out of service.

Ms Delamothe—And, hence, our main liaison is with public health, because they are the more similar model.

Senator MOORE—And they are bursting.

CHAIR—Have you had any occasions where people have not been able to get into the state services where you think they should have support from other programs?

Ms Delamothe—Yes.

CHAIR—And what do you do then?

Ms Delamothe—We do the best we can.

CHAIR—Under the existing program?

Ms Delamothe—Yes.

CHAIR—What happens when it comes to crunch time at the end of the 12?

Ms Delamothe—You do the best you can in the time you have got allotted, and sometimes that means narrowing stuff down to some stuff you can manage in that time and not trying to take it all on. The other thing that we have done in our division is to start to work with, in various arrangements, psychiatrists. So we have had a child and adolescent psychiatrist working in consultation liaison with us for three years, and so there is some movement between psychiatrists and psychologists, and the psychiatrist works under Medicare so he is not limited in the same way that we are. We are hoping to enter into a collaborative arrangement with state mental health to get adult psychiatry, because they have the workforce that we have not, and to try and be brokering a combination.

Senator MOORE—Is there a mental health service at each of the three hospitals with which you are working?

Ms Delamothe—No.

Senator MOORE—We know more about Hunter than just about anywhere else, because they keep popping up. So there are a number of major hospitals but there is one major mental health service at—

Ms Delamothe—It is at Calvary Mater. There are three hospitals: John Hunter is the main physical health hospital and the one for tertiary referral; there is the Calvary Mater, which has always done the deliberate self-harm and self-poisoning presentations, but it has a new section where the mental health service resides; and then there is Belmont.

Senator MOORE—Ms Wells, you have been trying to say something for a while.

Ms Wells—I just wanted to point out that the scenario that Katrina is describing to you is illustrative of the role—we tend to call it a brokerage role—that divisions of general practice play. If you think about the policy objectives of the Better Access program—the item number, fee-for-service based Better Access program—and the block-funded funding model for ATAPS, I think the role that the divisions can play in a brokerage sense is to promote team based care through putting in place systems where the feedback about how a patient is tracking is systematically provided to GPs through e-health enabled communications, as Katrina said. That was very much a policy objective of Better Access. I think ATAPS and the general practice interface makes that policy objective real in a much more meaningful way.

The brokerage with the state health system to improve the patient pathway is the other thing, and I think it also highlights the fact that there are deficits in a strictly fee-for-service based funding model that ATAPS is an extremely valuable complement to. I do not think it is a matter of Better Access and fee-for-service versus the ATAPS funding model; they are actually complementary, and very powerful from that point of view.

Senator HUMPHRIES—I just want to follow up on one issue that was touched on, and that is the capacity to provide, effectively, training and education to GPs, given the other pressures on them at the moment. I recall that when the Senate Select Committee on Mental Health asked about the take-up rate of the Better Outcomes in Mental Health Care programs we were told that about 20 per cent of GPs had done the course and that there was trouble lifting it above that 20 per cent. I do not know if you have any more up-to-date figures on take-up rates of these sorts of programs, but doctors I speak to are saying to me, ‘We can see the value of these things but we need another half a day off to do a training program like we need a hole in the head.’ Is it realistic to look at deferring some of these things until we have more GPs in the system, as well as other health workers, as appears to be the intention of the present government funding policies, before we realistically get many of these programs to bite amongst those areas of the workforce that are not using them at the moment?

Ms Wells—I have a couple of comments in response to that. You are absolutely right—I think the uptake of the training under the forerunner program to Better Outcomes was about one in four GPs. As a result, some of the training requirements were relaxed. I think there would be a cohort of GPs—it is probably a third, a third and a third scenario—who embrace the opportunity for additional training and upskilling in this area very vigorously and did so and continue to do so. There are the pragmatists who participated in the training because they saw it as being of value but primarily because it was of benefit to their patients, because if they were trained that was their gateway to access the Medicare incentives but, more importantly in the interests of their patients, the referral pathways into ATAPS. Then there were some GPs who rightly or wrongly argued, ‘We’re already trained in this sort of stuff; we don’t need extra training,’ and some GPs who are members of the Australian College of Psychological Medicine who are almost quasi-specialists in mental health delivery. So they are not a homogeneous group.

AGPN and the divisions network are quite major providers of mental health training for GPs. We have been increasingly providing that on a multidisciplinary basis, so it is quite common now for GPs, psychologists and mental health nurses to participate in continuing professional development training together, which has lots of other spin-offs in terms of their cross-professional communication. To give you an example of the level of interest in training, we have just been implementing a training program for GPs called Young Minds, which is a beyondblue funded package. I think we have had almost three-quarters of our members take that up and offer it to their GPs. It is a complex picture, but they are the comments I would make on that.

Senator HUMPHRIES—While we have such a serious GP shortage, ought we to think about trying to provide modified versions of these training programs to other health professionals who might be able to pick up some of the slack, such as the nurse practitioners that have been rolled out in some practices?

Ms Wells—I think there is a role for any clinician—and I am not a clinician, so I would defer to my clinical colleague here. But I suppose from a pragmatic point of view all clinicians—be it a nurse, a GP or a more specialised provider like a nurse practitioner or a psychologist working in primary care—should be trained and part of the pathway. Practice nurses are a growing workforce, for example. They work in a team based environment with GPs. They do not work independently. But there is probably quite a scope there for the role of the practice nurse in basic mental health literacy and a basic risk assessment role and function within their scope of practice and under some sort of supervision by a GP. That has not been explored but that is a workforce that could play a role in mental health service delivery, provided it is within the scope of practice and safety and quality issues are considered—for sure.

CHAIR—I want to go back to the issue of you not being able to take patients that come out of mental health hospitals or facilities. What was the basis for that? Is it a restriction put on the way that you can operate or is it a state restriction?

Ms Delamothe—No, it was in the guidelines for the pilot project. As to the reason behind that, I am not actually sure. But, guessing, I imagine it would have been factors related to the possibility—and we certainly spend some time, unfortunately, not taking on those people—that we may have been swamped by that because of the paucity of community mental health services. I will get much more clinical now. We need to think of people at risk of suicide and self-harm. There are, kind of but not quite, two distinct groups. There are the people who have enduring or sometimes complex and chronic mental illness, which requires long-term care—suicide and self-harm can often be a very chronic and enduring part of that—versus the cohort that we are seeing—and I think the evidence for our intervention is much stronger and should be the one seen by primary mental health care—which is those who may have a common presentation high prevalence plus or minus some situational factors that are acute, such as finance or relationship breakdown, and for whom the suicidality is transient and ultimately the condition and the suicidality are resolvable. They are not, largely, the group that end up in mental health services. They do not take them because they have not got room for them. So we do not want the enduring chronic and complex. We do not think that is our business.

CHAIR—We have had witness after witness talking about the fact that there is no support for people when they are coming out of these situations. So, instead of trying to load them onto the ATAPS program and what you are doing, what we really should be doing is boosting additional funding and support services that are complementary to existing services but specifically aimed at supporting those complex, more acute cases. I am thinking about how we are going to write our report and what we should be recommending to government around existing programs and where the gaps are. It seems to me that is a gap that we are seeing all over Australia. What should we be saying to government? If you were writing this report, what would you be saying to government about that specific cohort?

Ms Delamothe—What I would be saying about the system is that we need a primary mental health care system that is about a stepped model of care, so that we are not inappropriately putting pressure on the hospital system and on ATAPS, as you say, but we have a structure or a system where people can be stepped up or stepped down to the appropriate level of intensity of service response for their needs—the right care in the right place at the right time type principle.

Senator MOORE—That is exactly what we have not got.

Ms Delamothe—Yes.

CHAIR—What we have not got is that program where we are stepping them down—true. We have not got that next step to step them down to.

Ms Delamothe—Yes. They have conducted a review of the ATAPS program over recent months. It is a recurrently funded program, so it is not under threat. But what ATAPS has demonstrated is that it has filled a service gap and, as Katrina said, it is well embedded in the primary care space now. It provides a very powerful platform where you could add in, a bit like the building block scenario, using the same funding model but just extending the funding base so that there are some less intensive interventions at this end and some more intensive ATAPS-plus type interventions at the other end.

CHAIR—Can you remind me of when the funding for the pilot program runs out?

Ms Wells—June.

Senator MOORE—It was December and it got extended.

CHAIR—Yes, okay. And that is the same program—

Senator MOORE—As the crisis people.

CHAIR—It is a bolt added on to that. It is the end of March at the end of next week; there are three months to go. Have you been given any indication of what will happen? You have been commenting that people were reluctant to get involved in the pilot, so what happens in June?

Ms Delamothe—That is a good question.

Ms Wells—We are aware that there is an intention to keep funding the program. As I said, it is recurrently funded.

CHAIR—That is the ATAPS—

Ms Wells—Yes—ATAPS. I believe the intention is to look at how the suicide pilot could be integrated in and rolled out as part of the ongoing funding base. There is a very clear wish by the government and by the department for ATAPS to continue to occupy that space of a very targeted service. It is a gap filler program, if you like.

CHAIR—You only got that pilot program with the added on suicide program in 19 divisions.

Ms Wells—And we have a capped budget. There are 19 divisions; that is correct. The overall funding parameters for ATAPS is about $28 million per annum.

CHAIR—Are all the divisions participating in how the ATAPS program is being rolled out to the divisions?

Ms Wells—Yes.

CHAIR—So all your divisions are participating in that and 19 are doing the suicide program?

Ms Wells—Yes.

CHAIR—If I understand what you have been saying correctly, that has been an extremely valuable addition to the current ATAPS program and enhances it significantly and your capacity to deal with clients as they present—

Ms Delamothe—To general practice, yes.

Ms Wells—And another 11 divisions—it may be a few more than that—are participating in a different ATAPS pilot of telephone CBT. That, again, is a response to issues of transport and rurality in terms of access to an ATAPS service and the challenges in some far-flung communities of getting clinical psychologists and other appropriate mental health workforce members outreaching into communities. That is another promising model. That is looking at the efficacy, I suppose, of telephone CBT but also the efficacy of combining some face-to-face therapy with back-up telephone therapy.

Ms Delamothe—Can I make a comment about that. The telephone CBT program is rolled out in rural and remote areas mainly and that does not make sense to us. If we are thinking about alternatives to face-to-face therapy because of either workforce or access due to geography, it did not make sense to us that telephone CBT—and this goes for internet applications as well—was only for divisions that were rural and remote. If you think about the capacity of some of the regional and, dare I say, metropolitan divisions, it does not matter where you have the clinicians sitting on the telephone. So, for example, our division would have an enormous capacity to support—

CHAIR—You have enormous expertise.

Ms Delamothe—internet therapy and telephone therapy. You can do it for anyone anywhere. It does not actually matter. We are restricted in doing that because we are a regional division. It is an adjunct to that.

Ms Wells—Good comment.

CHAIR—Yes, thank you. I think we have covered a lot of ground. As you can see, we are all absolutely fascinated and very engaged with these issues. This has really helped me get a clear picture now of how the divisions fit into the scheme of things and how they are providing services. I personally very much appreciate it, and I am sure the rest of the committee very much appreciate it as well. Is there anything we have not covered that you want to add before we finish?

Ms Wells—No, I think we have covered the issues we wanted to cover with you. I would draw your attention to our submission to the federal budget in which we continue to advocate very strongly for the sort of system of primary mental health care that we have talked about today, particularly in the context of the broader health reform agenda, where there is quite an emphasis on care in the community: where most people go for care is where we should be putting the effort into our health system.

CHAIR—Sorry, I do have one more question. You touched earlier on the issue of working with other community based organisations. You used headspace as an example and we have had quite a bit to do with headspace through other inquiries and also through lobbying along the line for more money or for continued funding for it. You said you interact with a range of other community organisations that work on these issues. Would all the divisions throughout Australia have a level of involvement or is it specific to certain divisions?

Ms Wells—I think it would be variable. I think it is a product of lots of different things—the philosophy of individual divisions, opportunity and the receptiveness of some other non-government organisations, for example. A good example is the Personal Helpers and Mentors Program operated by FaHCSIA. I suppose if you were thinking about primary mental health care as a system you could easily argue that that workforce, which is about social recovery and supporting recovery on discharge—albeit focused on patients with conditions at the severe end—should be integrally linked with the primary care system.

CHAIR—Is it not?

Ms Wells—It is not, but it is in some regions and that is often a product of the relationship between a division and the primary care champions, if you like, and their relationship with the non-government provider that is auspicing that service.

CHAIR—So how do we get a map of how the programs and the divisions and various organisations fit together and interact? Because obviously it works. I am guessing that it works better in some areas than in others; some of that will be specifically organisationally or individually based, depending on key individuals.

Ms Wells—Correct. Yes.

CHAIR—And some will be more—

Ms Wells—More systemic?

CHAIR—Yes. So maybe we should be talking to the department about how we get a map—without it being a spaghetti nation—of how all the different programs fit together with organisations, not just an organisational map of how the programs fit together. How they are being delivered together is what we need.

Ms Wells—I think the other important thing is awareness. For some of the organisations that are auspicing PHaMs workers, for example, which I believe to be organisations like the Salvation Army and Anglicare, an important part of the picture is their appreciation of the role of primary care and perhaps the role of a division as a broker, not so much as a GP-specific body, if I can draw that distinction.

CHAIR—Okay. Thank you.

Ms Delamothe—I think there are some potential silos within mental health care but also between different departments: social welfare, health or whatever. I wonder whether moving towards some sort of organisational framework that is perhaps being mooted that covers primary care for a community has the chance to umbrella a lot of these different—

Ms Wells—The proposed primary health organisations.

Ms Delamothe—Yes.

CHAIR—Okay. Thank you very much.

Ms Wells—It was a pleasure.

CHAIR—I found your evidence extremely useful and engaging. Thank you.

Proceedings suspended from 2.59 pm to 3.17 pm

PRING, Dr William James, Chair, Public Health Committee, Australian Medical Association

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

Dr Pring—Thank you, yes.

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

Dr Pring—Thank you. If I may, I would like to read my opening statement to you because I think it is quite important to emphasise a number of issues in our submission along with some other issues that we think are important.

The AMA welcomes the opportunity to address the committee regarding the important problem of suicide in Australia. Every day and night across Australia, in general practices, psychiatrists' consulting suites and hospital emergency departments, doctors provide care to people who are contemplating, or who have attempted, suicide. Doctors also provide the care that they can to the family members of individuals who tragically have ended their lives. The AMA believes that with the right capacity in the health and community service system many suicides could be prevented and those who have attempted suicide could be given the care and support they need to recover. Currently there are gaps in that capacity. Those gaps will affect everyone but mostly they will affect the individuals in those population groups that are at greater risk of suicide including young people, those living in rural and remote locations, Indigenous Australians and the elderly.

The AMA believes that these groups warrant specific measures targeted to their particular circumstances and needs, and I will indicate what these are shortly. Importantly, these specific measures need to rest on the solid foundation of a well resourced and responsive service system in the community and in acute care settings. The emotional and mental health problems that may lead to suicide are complex, often difficult to detect and require persistent care to mend. The committee has no doubt heard that the current service and support system could be strengthened at many points to better achieve these things. The AMA believes that there are three critical points in care provision that warrant the committee's particular attention. These relate to the role of general practitioners in early identification and referral; the need for specialist follow-up services to provide points of referral and continuity of care; and the need for supported accommodation and transitional care back into the community.

Firstly, I will speak about the role of general practitioners. Nearly 90 per cent of Australians visit a GP each year. This gives GPs a tremendous opportunity to assist in the early identification of suicidal intentions and to enable prevention of suicide. But GPs need to be properly equipped to do this. Suicidal intentions are not always apparent and skill is needed to accurately identify and appropriately refer. Many GPs have those skills but not all. The AMA believes that support in the way of specialised training and time is needed to allow all GPs to appropriately maximise those opportunities.

Secondly, I will turn to specialist follow-up services. Regardless of how well GPs identify individuals at risk of suicide, there needs to be a set of steps for referring those individuals to further care. Needless to say, the care that such individuals need must be specialised and sustained. There are significant weaknesses in the availability of specialist follow-up services for individuals who are at risk of suicide or who have attempted suicide. Particular attention must be paid to how specialist mental health services can be better arranged and resourced. There is an urgent need to review and provide adequate resourcing to psychiatric specialist long-term community care so that the cases identified by general practitioners and others can be adequately treated and so that suicide can be prevented more effectively. A high proportion of people who complete suicide suffer from serious mental illnesses. I do not know that that is commonly recognised. Certainly I was involved in a study that the Victorian coroner did looking at completed suicides and as a scoping process for that study I got to look through the case notes of the suicides of 30 young people, and 60 per cent of that particular sample had evidence, in testimony from doctors and nurses and family and from the suicide notes, of psychosis or major depression particularly or mood disorder. The most common of the serious illnesses include recurrent mood disorders, schizophrenia and episodes of major depression. These major disorders often have a significant biological component. They usually require specialist psychiatric management and in many cases they are likely to be recurrent throughout a person's life.

The ongoing specialist oversight these conditions require is not currently available sufficiently to all Australians afflicted by such conditions. There is a very significance evidence base for what is likely to be successful in treating such serious mental illnesses and suicidal behaviours they can produce. The evidence points strongly to appropriate psychiatric management usually involving medications or electro-convulsive therapy and a significance supportive psychotherapeutic relationship with the treating doctor if it is to be successful. If people who have recurrent serious mood disorder are given adequate treatment, often with medication and in the setting of a strong, ongoing, supportive psychotherapeutic relationship, such people can recover to the extent of being able to re-establish significant roles in their lives, sometimes working, manage their illness so that it has minimal impact on the lives of the long-term and avoid suicide.

All of this points to the need for people who are identified as suicidal to be assessed by a psychiatrist as soon as possible to comprehensively diagnose their condition and commence a treatment plan. It is particularly important that people have specialist psychiatric follow-up over a number of years if they suffer from a recurrent major mental disorder. Because their disorder is likely to relapse over time, it is important for those people to have expert ongoing management over many years and often their entire lives. That does not mean that psychiatrists have to do all of that follow-up, but they need to be directing the overall long-term management.

The AMA notes that there are insufficient specialist psychiatric services available, an insufficient number of psychiatrists and the possibility of workforce problems in this area into the future. The AMA applauds the recent COAG commitment to support general practitioners and psychologists in providing community based mental health services, with a resulting increase in case identification of people suffering serious mental illnesses in the community. But there has been no concomitant increase in the specialist psychiatric services available to treat such people, and therefore there is a significant mismatch between the intentions of COAG in this area and the results. The AMA believes that this mismatch is partly due to limited consultation with psychiatrists on the part of governments, and the AMA is well-placed to assist in establishing appropriate channels of communication.

Thirdly, I would like to discuss supported accommodation. The AMA does recognise that there have been other improvements in recent years in the mental health care and support available to people at risk of suicide. The benefits that this care and support provides in people's recovery can easily be eroded if the necessary support is not there to transition people back into leading healthy lives. A crucial part in this transitional care is supported accommodation and carer education and support, and there is a lack of these. If individuals who have received treatment for their condition are forced to return to possibly dysfunctional environments then the good work can be very easily undermined. The current level of supported accommodation services is unable to meet demand. The AMA believes that there must be greater investment in this dimension of transitional care.

I would now like to look at the groups at risk. Addressing these three priorities that I have outlined—GP support, investment in specialist services and investment in supported accommodation—will go some way to strengthening the service foundations that will allow better targeted support to population groups that are particularly at risk. The AMA's detailed submission lists the measures that the AMA considers most important for early suicide intervention and prevention in at-risk groups in Australia. These measures include: for teenagers and young people, removing the barriers to them accessing doctors and developing an ongoing relationship with a GP; for people in rural and remote settings, raising community awareness of suicide in remoter locations and developing community capacity to identify people at risk and intervene appropriately; for Indigenous Australians, improved access to culturally appropriate suicide prevention programs and increased awareness among Indigenous people of mental health issues and social and emotional wellness; and, for the elderly, increased awareness among medical professionals of risks among the elderly, and age-appropriate follow-up services and interventions.

There are also other groups for which suicide appears to be an emerging problem. As the peak organisation representing doctors in Australia, the AMA is aware of emerging risks of suicide among junior doctors, who work in high pressure and demanding environments, sometimes without adequate support or opportunities for self-care. The loss of a young doctor through suicide is a tragedy in itself. But it is also a tragedy for the system that that doctor is no longer able to contribute to society, and for other doctors in the profession it is a great tragedy. The AMA believes that greater attention should be paid to this growing problem in the medical workplace.

Senator HUMPHRIES—Thank you for that opening statement. I would like to touch on an issue I raised earlier with the Australian General Practice Network, and that is the question of how to bring more doctors and, for that matter, allied professionals to a point where they have the necessary tools in front of them to be able to identify and address issues of mental illness which might make a person prone to suicide. We heard that 20 to 25 per cent of doctors have undertaken the Better Outcomes in Mental Health program, which would provide those sorts of tools. We also understand that the huge pressures on doctors, of which there are a serious shortage, leads to others not having the time to go and do those sorts of programs. Realistically, what do we do about that problem? We can defer this question until the money that is currently being pumped into the system produces X-thousand more doctors in 12 years time, or however long it is going to take, but are there alternatives to empowering health professionals and others in the system to be better educated about these sorts of problems and not reliant on those overworked doctors to continuously identify and move to treatment options those people that they see?

Dr Pring—I think I have got some ideas about that. First of all, maybe we need to look at whether we can improve the type of education general practitioners are getting—maybe with similar funding. It is a matter of making sure the general practitioners are well aware of some of these serious mental illnesses. A number of these disorders are called 'low-prevalence disorders'. The GPs may not see them often enough to feel really comfortable with the right approach to them. So it is very important that they get adequate training, and we have highlighted that in our submission.

In preparation for today, I looked at the *Hansard* and the submissions to the inquiry, and there was one thing that was obvious to me. So many completed suicides, and a lot of attempted suicides as well, are people with serious recurrent disorders. These people are likely to attempt suicide a number of times throughout their life unless they are adequately treated. So we need to make sure that the specialist services are adequate. We are identifying cases through the COAG process. GPs, psychiatrists and many more people out there are identifying people with serious mental illnesses. I am getting complaints, even from some of my regular referring GPs, that they cannot get people in to see a psychiatrist in either the public sector or the private sector, even when they have identified a serious condition. There seems to be a bit of a logjam in the system now. With the COAG process that occurred, we have got a lot of identification. I think there was a hope, from the political area, that that would help to solve a lot of the problems within mental health. It looks like it is not entirely solving the problems. That may because there was relative neglect of the enhancement of the specialist mental health sector. So how could we improve that situation in practical terms? Firstly, there is a looming problem with obtaining a psychiatrist. It is hard to retain psychiatrists in the system. We need to look at that as a high priority. We have a review of the mental health workforce happening at the moment. Hopefully, that is a very important aspect that might come out of the mental health workforce review, which is a governmental review at the national level. So that is one thing.

The other thing is that, obviously, there are not enough psychiatrists to see all the people with serious mental illnesses. So we need some enhancement of the system to allow those people who are identified to be assessed by psychiatrists but then managed by other mental health practitioners—but with the psychiatrist providing leadership in a way that the psychiatrist feels is secure. Setting up the processes is one of the most difficult things. As a psychiatrist, as I am, once you have seen a person who has a serious mental illness and you have assessed them and you have assessed that they have a high suicide risk, you need to know that the people you are working with fully understand the huge risk that we are carrying until the person is adequately treated. Often we are treating them in the community, not in hospitals if we can avoid it, and that is a huge risk. It is a very heavy responsibility that you feel.

I am predominantly in private practice, but I have worked 33 years in psychiatry and I have worked in general hospital psychiatry in the public sector and in private psychiatry throughout that time. I think that, in the private sector, when you take on a person you make a commitment to try to get them really well—to recovery. That has high labour input and there is a huge responsibility on your shoulders. To start delegating that responsibility to other people, you need to be absolutely rock-solid sure that you know how those people are working, that you are communicating frequently and that the patients are getting the best possible care between the times when you actually review them.

If people were interested in consulting with psychiatrists about how that could be done, I think we could actually find ways of doing it. It was interesting that, in COAG for instance, the extra contribution to private psychiatry was, I think, $5 million per year or something like that. That did not go anywhere near allowing us to set up, unfortunately. We would like to be able to work more with psychologists and other mental health practitioners in the community, as the GPs have been able to. However, in a sense another paradoxical effect of the COAG process is that, in some ways, the psychologists—not all psychologists, but some psychologists—have sometimes found the serious mental illness cases very difficult to deal with and they have often panicked and sent them on to us. They have identified them, but have not been willing to continue working with us with those patients. We need a group—a cohort. We originally actually recommended that clinical psychologists be the first ones allowed onto Medicare and at a decent sort of rebate—they might get an enhanced rebate if they were willing to work with us on these cases. That might have allowed us to set up a system that was better for looking after these high-risk people.

Senator HUMPHRIES—I have to confess to being a little bit unconvinced by the suggestion that enhancing the work of psychiatrists is the key to this particular problem. We heard, during that enquiry a few years ago, that there was a serious shortage of psychiatrists and that in some states you would find, I think, 90 per cent of psychiatrists would be practising in the CBDs of the capital cities and would fly out to regional centres, but very few at all were based outside capital cities. The $1.9 billion mental health package announced in 2005 deliberately emphasised giving psychologists Medicare registration and putting more social worker type positions out there in the community—personal helpers and mentors—in recognition of the fact that there was a shortage of the most highly qualified people in the sector—that is, psychiatrists—to address these issues. The situation is really no better today, is it? Proportionately, we do not have any more psychiatrists than we had back in 2005—

Dr Pring—That is correct.

Senator HUMPHRIES—but the problem is no less and is probably greater, if anything. I do not mean suicide specifically but mental illness generally. It will take a long time to train up more psychiatrists through the initiatives that the government is taking at the moment. Is it realistic to focus on a system which is dependent on a relatively small number of psychiatrists when you might argue that others in the sector might be able to shoulder a large proportion of that load, for example mental health nurses. We are seeing practice nurses going into general practice in larger numbers. Should we be training those people to share a larger proportion of the load?

Dr Pring—Certainly the AMA is not against training up GPs and practice nurses in general practices, because obviously we cannot just rely on psychiatrists. I point out that for various reasons that initiative, whilst directed to GPs and psychiatrists, has not been easily taken up by private psychiatrists. If people want to talk to us about that, I think we could actually devise systems that were effective in including practice nurses in our own practices in private psychiatry. I do not want to overemphasise private psychiatry either, because a lot of the people that are suffering these serious illnesses are also being seen in the public sector obviously. There we have problems because the public sector is often trying to discharge people into the community, into general practitioners’ hands and private psychiatrists’ hands, but then there is often a lack of coordination back again; when people do have a relapse it is very hard to get people back into the acute system in hospitals and so forth for private psychiatrists. So it is very difficult. We used to have better working relationships, I think, some five years ago. We need to look at all of that and see how we can make it easy for private psychiatrists to work in with the public sector, for instance. I only emphasise private psychiatry to an extent because in the specialty servicing area in fact private psychiatrists see approximately 60 per cent of all Australians who come to care to be seen. We know that there is still a significant unmet need group, but of the people that come to be seen by specialist mental health services 60 per cent come to private psychiatrists.

I thought in what I said earlier I was emphasising that psychiatrists cannot do it all and that we would like to be talked to very seriously about how we can leverage ourselves in a sense and look after more people in the community, including in rural and remote areas. I point out to you that there is good evidence in a report that came out, the Burgess report, I forget the full title, in about 2001. It is the lead government commissioned look at population mental health needs and how they being serviced in Australia. That seemed to show that there was a skewing of private psychiatrists away from rural communities and that there was less skewing for the public sector. It was based on the amount of money that was spent in different local government areas. If you look at the number of people seen, and especially if you look at whether psychiatrists have actually assessed people or not in country areas, from an analysis of the raw data included in that report it would look as though the private sector, while skewed towards metropolitan areas, is less skewed than the public sector. That is a very serious situation because you would expect that the public sector might in a balanced system between private, and public and there is a lot of evidence around the world that private and public balanced systems actually get treatment to the broadest level of the population through the combination of public and private systems, you would have thought that the public sector might actually try to make up the difference where the private sector finds it difficult to do so. There are a lot of other things. I could talk to you for hours about the nuts and bolts of why these things work and do not work, but that is a brief description.

Senator HUMPHRIES—If someone comes and talks to the psychiatrists about that, I hope someone is talking to psychiatry about these issues. I recall that a couple of years ago some of the money that had been made available under the mental health initiative in 2005, or 2004, had been withdrawn on the basis, we were told, that there was not a sufficient workforce to deliver some of those services. There had not been enough people coming forward to specialise in mental health nursing for whatever reason.

Dr Pring—Yes, there are the workforce shortages.

Senator HUMPHRIES—As far as you are aware, is there a process whereby the profession is able to engage in a dialogue about managing those workforce issues?

Dr Pring—There are lots of venues but I am not sure that we are being heard. I have been trying to get some of these messages across for some time and it has been difficult. It has been very encouraging that government has listened to general practice and psychologists because I think really the result of that initiative is that there is much less stigma is my impression in the patients I see to be presenting for care for mental health problems. I think that is a wonderful thing that has come about by the greater awareness. It is not just that initiative; it is beyondblue and so forth. But the AMA is very applauding of that initiative. It has been very good needs but it needs adding to if we are going to actually improve things. And it is really critical for the group of people who are likely to suicide. That is what I am talking about here.

Senator HUMPHRIES—I want to ask you a couple of questions about which is said in your submission about the elderly. You say, or the author of the report says, that suicide in the elderly is often overlooked. What is meant by that: that it is not reported, it is understood but not being researched enough?

Dr Pring—It is not identified, I think. I think that is what people are saying. You will actually see it in some of the other submissions. I think Professor Goldney's submission goes into this to some extent too. With older people, the reason we are interested with older people particularly is that, whilst there are not huge numbers of older people who suicide, on a per capita basis it is quite a high rate. We want to prevent that. It is often associated with multiple physical illnesses, obviously. I think that is where it may get neglected. When people have multiple physical illnesses, of course they going to get down to some extent, but are they getting down so much that they want to kill themselves? You have probably had submissions from end of life euthanasia people and so forth and you get into that area, but having worked in general hospital psychiatry for 25 or so years, I can assure you that the general medical surgical hospital population is largely elderly and so I was often being called in to assess whether an older person's reaction to their multiple illnesses was treatable depression or a natural response to their situation, which usually people will get better from gradually once they have time to talk and so forth. Unfortunately a number of older people are quite severely ill particularly. Sometimes otherwise too, as they can suffer from mental illnesses just like anyone else can, severe ones too, but also we are thinking there is a higher per capita rate of suicide in elderly people because of multiple physical illnesses, and people sometimes neglect the fact that if you actually treat those people actively for those depressions you can both save them from suicide and actually help them recover. A number of times in my work in general hospitals it was a matter of trying to get the treatment to the person in the nick of time so that they would not just deteriorate from their medical conditions. Then you had the enjoyment of being able to see them really improving and getting out and living their lives for another five or 10 years or whatever it was going to be and being very healthy and happy about that. That is what we are trying to make a difference about.

Senator HUMPHRIES—You also say that it has been suggested that the elderly often choose more lethal means of suicide. What do you mean by that exactly?

Dr Pring—It may be to do with intent, which is not specific to elderly people but also to anyone who has a serious mental illness. They seem to be less put off by more violent and dangerous means of suicide, such as hanging, shooting or drinking caustic soda or whatever it might be. Some of those sorts of conditions when they do not kill people cause terrible situations too.

Senator HUMPHRIES—I want to look at the situation of older people, particularly those facing serious or multiple illnesses. Would you say that the problem is a lack of support for their mental condition to understand and cope with their illnesses, or is it essentially a lack of support to deal with and treat those illnesses that is the root cause of this problem?

Dr Pring—It is probably a bit of both. I do not want to be too obtuse about things, but it is probably a bit of both because obviously we have also found that elderly people on their own with physical illness—people without support—are particularly at risk of suicide. So social supports are very important as part of the whole package. I think general practitioners are much more aware than they have been in the past about this risk in the elderly population. However, it is always good to keep reminding general practitioners about that and having them upskilled in that. Also, if all the other people who are working in the aged-care area are aware of this and the eminent treatability of severe depressions in elderly people and the consequences if they are not treated, then we will have more case identification for GPs to be able to initially take over and give treatment and maybe seek advice if they need to.

Senator HUMPHRIES—Is a lack of, for example, adequate pain management a significant factor in suicide of the elderly—

Dr Pring—Yes.

Senator HUMPHRIES—and is it an area where doctors can do better in identifying and dealing with that issue, particularly if it is interacting with things like depression?

Dr Pring—Certainly, yes. That is true. Again, general practitioners have become much more aware of those issues. I know a number of my GP colleagues are going actively and frequently to pain management updates because it is relevant not just to the elderly population but to all. Certainly, it is a very significant factor in elderly people where they perhaps believe the pain is going to go on at the same high level indefinitely and they feel that life is not worth living, not like this. Getting adequate pain management is important but it is quite tricky. There are some wonderful patches that you can put on that have a long-term release of painkilling medication. It is quite effective, but if the dose is not quite right or if something else goes wrong with a patient temporarily, like a urinary tract infection, they may become extremely confused on the same dose, so the patches have to be cut down or decreased. So highly skilled management is actually what is required to do that. Yes, it would be good to get excellent pain management for elderly people—but it is also a factor with younger people who have chronic pain. They can suicide too in those circumstances.

CHAIR—We have had quite a lot of evidence about the fact that a high proportion of homeless people have mental health issues. My question is about their ability to access GPs. I would suggest that they are probably not accessing GP services as much as the rest of the community and not having a way into the system once they become homeless. It would seem that in a lot of cases their mental health has played a role in them becoming homeless. How are homeless people able to access systems at the moment? What is their way in if they do not have an existing care plan when they become homeless, for example?

Dr Pring—That is a very big area. It is true that there is a lot of evidence that many homeless people suffer serious mental illnesses and that may be part of the their homelessness as well. I do not think that the services are very well developed. It is difficult, because homeless people are often distributed across a city in different places and they often have to be gone to rather than expecting them to come anywhere. I have looked into that to some extent with one of my colleagues, a GP who is President of the Victorian AMA at the moment, Harry Hemley. There are a few people like him who have devoted a certain amount of their weekly time to homeless people as a charitable exercise. He cannot possibly get to all the homeless people, obviously, but he has put in a consistent effort. I know that a number of other GPs have done that in other capital cities as a public good, I suppose, but it is really not good enough because it is not organised across areas. In the specialist mental health area I think a number of states have set up homeless mental health teams that actually go out and try to deliver services to homeless people. They work to varying levels of success. Of course, it is hard to get adequate funding to provide an adequate, ongoing service, and it is very hard to provide any ongoing services because with the homeless person there are often problems of identity: identification of who is who and whether you are seeing the same person consistently, if the homeless person moves around. So there are a lot of logistic issues to it as well which make it very difficult. I know that Harry works by providing his services from a homeless shelter. He goes on a regular basis and has managed to see some of the people more regularly. He understands that he is often not going to cure things but that he can make a difference; he can decrease harm that might come to people otherwise.

Senator MOORE—Medicare coverage is very hard too.

CHAIR—Yes. Senator Moore was just saying that Medicare coverage is very hard.

Dr Pring—It is very hard for identification problems. With healthcare identifiers it might even be harder.

CHAIR—We were talking earlier with the Australian General Practice Network and we talked a lot about the ATAPS process. We also touched on the issue of people being discharged from mental health facilities and those people not being able to be dealt with by the ATAPS process. We had a discussion around a more intensive or different system of support for people who are specifically coming out of acute care. How does that fit into your scheme of things in terms of, as I understand it, having a psychiatrist who oversees the care plan but then other people deliver other parts of the care plan? That is my simplistic take on what you have been talking about.

Dr Pring—I am not aware that there has been much input from psychiatrists into the ATAPS program. I actually read the AGPN submission as well, and I was trying to see where we had been involved because I was not, as a psychiatrist, so knowledgeable about that particular program. So I do have to say that from the beginning—

CHAIR—Is that ATAPS or the extended processes—the specific programs around suicide prevention and risk?

Dr Pring—I was thinking of the suicide prevention and risk programs. I am not sure how long they follow up their people.

CHAIR—For the suicide risk program they have got two months of unlimited numbers of consultations and they can then be referred back into the broader ATAPS program, where they then can have up to 12 months. What they were saying this afternoon is that if they identify specific high risk factors they then try and refer them into the specialist programs.

Dr Pring—Yes. I would think that is where it lies. So, in a sense, they are triaging into the specialist system. Are they saying they are finding it difficult to find places? Yes. That is what I am being told by my GP colleagues. What was predicted by the AMA in 2006 when the COAG initiative was floated was that we would have much greater case identification, which is great, but if you do not actually provide the ongoing services then it actually has a negative effect. People will start to give up bothering to identify. What is the point if you cannot get services for people?

It actually has a very corrosive effect. It has a corrosive effect on us because we are looked at very adversely by colleagues: general practitioners, psychologists and mental health nurses. Mental health nurses understand a bit more because they are facing shortages too. Of course that then impacts on whether a young doctor wants to go into psychiatry, because you are holding people for years with very high risks. If you work in a system which allows you to look after people in the long term, that is where you get your satisfaction, because you can actually prevent people from suiciding and you can help them live good lives.

Consumers and carers talk about recovery and I have seen that over and over again. It is very satisfying. It is really great. But it is frustrating—even if you think you are doing good work—if everybody else thinks you are not seeing enough people and they are pulling their hair out. We would like to be able to leverage our services more. I do not think we have been listened to, because we actually told the government at the time in 2006: ‘You will get more case identification and not enough specialist treatments, so that you as politicians will face dissatisfaction with the mental health system in a few years time, when all that case identification is occurring, and you won’t be getting adequate services to people who need it.’ I think that is what is happening.

CHAIR—You have got an unmet need out there.

Dr Pring—And it is important in relation to suicide because so many completed suicides are by people with ongoing, recurrent illnesses. In my own practice of about 33 years I have had eight people under my care suicide. It is an awful thing when it happens, but it is actually a small number compared to the people who are affected.

Senator MOORE—One of the things that has come up consistently is the communication breakdowns. There seems to be this loss of people. They are admitted into hospitals, often when there is a crisis—the only time they can get in is when there is a crisis—but there does not seem to be an absolute guarantee that they will then be released into someone’s care. There have been trials. One of the ATAPS trials is looking particularly at that to see if people can get released back to their GP. Does the AMA have any views about what the best methodology for that would be?

Dr Pring—I am not sure that it is totally a connection type of thing. Again, it is a complex area to get into and I have got quite a few opinions about it. Certainly, good communication is important in the clinical areas. I am suspecting that, with the more severely ill people, it is not so much a matter of communication as a matter of a lack of services, predominantly.

I suppose, if you are trying to refer people back to general practitioners, it does depend. I think the general practitioner workforce has been educated a great deal over recent years and is extremely advanced. But I think there are still some GPs that have difficulties working with people with severe mental illnesses and it might be better for them to know, whether they can or not, and for people to know that too. That might be a factor that is important. It is similarly so with psychologists. Some psychologists are very comfortable working with quite ill people and other psychologists are not as they might not have had the experience of working with seriously ill people during their work time. So I think communication is not the whole thing. The other day I was driving away for the weekend. This is to illustrate that for you. It concerns a patient whom I know very well and have treated over a number of years and who has had a baby recently and can be somewhat disturbed in her behaviour—seemingly disturbed in her behaviour at least because she has a severe attention deficit disorder in fact. I had a call about her from a person who was apparently a case manager. My wife was in the car with me and the call was on speaker. I did not reveal a lot about the person involved but I spent 30 minutes on the hands-free as I was driving along. In the end I discovered that that case manager had found out from me that I was in charge of things and they had nothing to offer me. That was half an hour of communication for nothing. There is quite a lot of that at the moment. That is very frustrating as a practitioner.

Senator MOORE—And would your recommendations in your submission about accommodation services fall into that same bucket?

Dr Pring—Yes. There is probably insufficient training and linkage. It would be useful if there were some linkage. A lot of the transitional services are actually housing perhaps 15 to 20 people with serious recurrent mental illnesses. Some public sector mental health services have recognised that and they provide quite a lot of supportive input to those homes, because it is all centralised for them and they can go and visit and look after people in those situations. We could probably do with more of that. Not all of those places are very kind or nice to people with severe illnesses but some of them are quite well run. It is helpful to identify places like those and to encourage training up so that places can look after the needs of people with mental illnesses and have the sort of public sector input—or maybe private sector input depending on how it can be organised—to actually give support to the owners of the accommodation so that when thinks start going wrong they are not left in the lurch and have to call for an ambulance or a policeman.

Senator MOORE—Yes, so they would have their own support networks.

Dr Pring—Yes. We also mentioned carer education and support packages. I really think that they could be quite useful as well especially where someone has made a suicide attempt. If they are connected to either family or other carers that are important to them, it would be educating those carers in how they should be. I often get families coming along to me and saying, at the family interview, ‘How should we be with our loved one? Should we tell them not to do these things?’ They are not sure how to deal with things, so they need that sort of input, which could be very valuable as well. To my knowledge, there are not a huge number of programs like that.

Senator MOORE—The Richmond Fellowship’s is probably one of the better ones, but that seems to be focused on one condition, as opposed to those of other people. One of the things that the general practitioners group that we had before was talking about was services and support for families. Their recommendation was that somehow people access services without the link to mental health in terms of process.

The only kind of available process now through the GP is to go through the ATAPS program and that needs a care plan, which is linked to mental health. They thought that that could be off-putting to someone who is just seeking the support they need to get through the grief and the shock of losing someone. That was one of their recommendations, which I had not seen offered by anyone else. There has been a lot of evidence in submissions about the need for services for people who are in that family situation. The Jesuits in Melbourne seemed to have a really operational system going but that was a recommendation for a different form, funded through Medicare. I was quite taken with that.

Dr Pring—It is interesting because general practitioners probably do a fair bit of this work, anyway.

Senator MOORE—Yes, in their normal practice.

Dr Pring—Yes. They will call a family in after a crisis, or they will be asked by other family members, ‘How are we meant to cope?’ Often a family might be at a particular practice, so GPs are often doing this. If a program was to be enlarged like that it might be well based in a general practice type of arrangement, maybe with some psychiatrist input as well.

Senator MOORE—With just a different focus, somehow.

Dr Pring—Yes, because it is helpful for people running those programs to actually understand serious illnesses—

Senator MOORE—Yes.

Dr Pring—to some extent, because if you delegate it to people who are maybe even anti psychiatry and anti mental illness—they do not believe in severe mental illness; drug companies have drummed it up, and all that sort of thing—then they can get the carers off on the wrong tangent. Then you have a problematic situation. So you need good quality education and support that has some understanding, especially if you are talking about serious illnesses. With the milder illnesses there is probably not quite as much need for intensive support. I have certainly supported a number of parents. It is tricky under Medicare, because people are meant to be ill before you see them. It is rare for a parent who has a child that is suicidal or drug addicted not to be anxious or depressed about it—

Senator MOORE—Not to be ill, yes.

Dr Pring—so I do not find it too hard to be able to see them. I find it really useful, because I know the condition, even if I do not know the actual person. Through the parents’ eyes or the other carer’s—the partner’s—eyes you know the condition and you can help guide them very accurately and helpfully. If I started doing that all the time—I possibly could—I would not be seeing any mentally ill people.

Senator MOORE—That is right.

Dr Pring—So, again, we have to leverage our services—our ability to help with education programs and so forth—so that others can do the job but with a sufficient input, educationally, that they understand what they are dealing with, to some extent.

Senator MOORE—One of the other major issues, Doctor—and you would be across it in your career—is the issue around privacy. So many people who are parents, family and carers come to us and say that their role would be enhanced if they had access to information about the condition that the person they care for is suffering. They would be able to have a more protective role. On the other hand we have consumer groups who say that it is absolutely essential that someone with a mental illness or who has thoughts about suicide has the dignity of their own privacy, the same as everybody else. We have been struggling with this particular issue through a series of inquiries in this committee. I have to admit, and I have said it before, that I am completely bedevilled by it. I do not know the answer. In your experience is there any way of working through that in a way that we can provide support to both groups?

Dr Pring—I have thought a lot about that. Another hat I have is that I am on the federal Privacy Commission’s community advisory group as a health representative.

Senator MOORE—You must have been very evil at some time!

Dr Pring—I must have been! I have thought about it a lot and I have been to a lot of consumer and carer meetings. I know exactly what you are talking about. The truth is in the middle, unfortunately, and that is hard for either side to absolutely understand.

And yet I know that privacy can be used as an excuse not to provide adequate input to carers in particular. In my experience the people who are most angry are the carers. It is often after they have lost a loved one; there is a lot of anger generated by suicide as well as grief. Part of the grief is anger and often a lot of it is directed towards us, and it is very difficult. I am also in that middle ground, and I make a point of trying to persuade them to involve family if they can—even to a minimal extent, because I think it is better than no involvement. But there are some patients who would absolutely not see me. In fact, I have been to a meeting where a person said, ‘If the doctor had contacted my family at that time I would have suicided.’ That was a meeting actually set up to get an answer going the other way for parents.

So it is a really difficult situation. I do not think we are doing a good enough job of involving carers as much as we can or giving them good quality education which is not giving them a bum steer, as I was talking about before. That is why I feel strongly about the carer education and support package that we have mentioned in our submission. We really could improve on that.

I think a very common problem—possibly for GPs, but less so because mostly they get to speak with families—probably for a number of different professionals, and it is true for psychiatrists: we are sometimes not comfortable enough in a large family group. We are just not practiced at that. I have certainly advocated to my college of psychiatrists that we actually institute in training a specific program of dealing with families and doing family therapy. I did a year of family therapy in my training and it has been eternally useful to me over my practice life because you are not scared of really explosive situations. I do not mean in terms of violence, but the emotions and strength of a family in uproar. Knowing what to do about it can be a bit daunting sometimes. I am not saying that happens all the time, mind you, but if you have handled that sort of situation, most family situations are easy to deal with and you learn ways of getting families working together and so forth. I think that sort of training for a number of professionals would be the single most likely thing to help in the professional area. An awareness helps as well, but you can have awareness if you have not had training like that—you may not be so confident.

Really good quality education for the carers which helps them to manage people with serious illnesses is needed and, preferably, some ongoing linkage would help the carers a great deal. I think they deserve that.

CHAIR—Thank you very much. We have gone way over the time that we said we were going to keep you.

Dr Pring—That is okay.

CHAIR—Your time and your submission are very much appreciated.

Committee adjourned at 4.18 pm