COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Suicide in Australia

WEDNESDAY, 24 MARCH 2010

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SENATE COMMUNITY AFFAIRS

REFERENCES COMMITTEE

Wednesday, 24 March 2010

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

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

Senators in attendance: Senators Adams, Marshall, 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 1.33 pm

BUCK, Ms Anne, Policy Officer, Australian College of Mental Health Nurses

RYAN, Ms Kim, Chief Executive Officer, Australian College of Mental Health Nurses

CHAIR (Senator Siewert)—The committee is continuing its inquiry into suicide in Australia. Welcome. Thank you very much for coming and waiting patiently for us. I understand you have both been given information on parliamentary privilege and the protection of witnesses and evidence. We have your submission. I invite either of you or both of you to make an opening statement and then we will ask you some questions.

Ms Ryan—First of all, thank you for inviting us here today to talk with you. You certainly have a big job ahead of you, so good luck with all of that. I would like to make a bit of a statement around what mental health nursing is. The first question people usually ask me is: what do mental health nurses do? I thought I would take this opportunity to say that mental health nursing is a specialised area of nursing practice committed to promoting mental health through the assessment, diagnosis and treatment of human responses to mental health problems and mental illness. Mental health nurses employ the therapeutic use of self as an art and wide-ranging use of psychological and neurobiological theories as evidenced in science for their practice. It is very much related to not only the psychosocial but also the neurobiological aspects of ones being. I wanted to start with that.

You have our submission and you will see in it the recommendations that came from the nurses in the survey that we undertook. Mental health nurses play a crucial role in mental health promotion, mental illness intervention and suicide prevention. But not all nurses that work in mental health services are specialised mental health nurses, and only a small proportion actually have postgraduate qualification and training in mental health. Looking at the numbers in New South Wales, for example, roughly 25 per cent of nurses that provide mental health care actually have a postgraduate qualification in mental health. That impacts on the service that our community gets in relation to mental health intervention.

Not only do we need to have a look at mental health nurses in relation to their education, understanding and training in relation to suicide prevention, intervention and identification, but we need to look at all the other levels of nurses and midwives who are involved in providing care to the community and come across people with mental illness. They come across people that are affected by suicide or are contemplating suicide, and that is a big area of nursing that we are not focusing on. We focus a lot on the specialised mental health workforce when we talk about suicide intervention and prevention.

A lot of people that at some point get to see a mental health professional have used the word ‘suicide’, which could mean that it has already been identified that they need support. We need to look at the group of people that may not be using that word and may not be seeking intervention. Healthcare workers having a conversation with someone in relation to another, physical illness may be able to pick up some key factors in the person’s distress.

We sometimes use the word ‘suicide’ too much, and that is another issue. In some health services, people are becoming a little bit jaded by the word ‘suicide’. There are numerous stories

from nurses and police of people who may be homeless or without accommodation saying they are suicidal to get overnight accommodation in a bed in a hospital. That is a problem, and that does end up jading some of people who provide the services, as well as affecting people's understanding of what someone who truly is suicidal is about. So there is real issue in relation to that.

The distress in our community is what we need to be focusing on, and I worry sometimes that we focus too much on one particular area of distress in the community. It really is about people being in distress, whether or not they are suicidal at the end of the day. If people are using the word 'suicidal' because they know that will get them the intervention they require, that is a problem. We need to be focusing on the distress in our community in a number of different ways.

CHAIR—Thank you.

Senator MOORE—One of the things we have heard is that people who identify as having suicide issues or who have been frequent attempters of suicide feel as though they are treated badly by the medical profession. We have got a lot of evidence from people and their families to say that there is prejudgment by the medical profession. Members of your college handle all kinds of issues all the time, so I would really like something from your perspective about that statement and what we can do to change that.

Ms Ryan—In some respects it goes back to the point I just made. People use the word 'suicide' too liberally, particularly in emergency departments. People have to say they are suicidal to get into hospital and people have to say they are suicidal to get inpatient admission. People keep saying that, and then the healthcare workers go, 'Oh, they're suicidal—of course!' But they may not be suicidal at all, and the healthcare workers get jaded by that. What happens then is the person who truly is suicidal gets lumped in with all the other people who may have to use that as a mechanism to get themselves into hospital or to get themselves some sort of intervention.

So I think that goes back to my point that we have to stop using the word suicide and start looking at what it is that people are actually suffering. People are actually suffering distress. For a lot of people, if you actually ask them, 'Do you really want to kill yourself?' what they want to do is stop what they are suffering from, which is the distress. They may not actually want to end their life, but they may not at that point see another way to prevent the distress they are feeling. So they say it, but it may not necessarily be the case. Everyone gets lumped into one group.

I think it goes back to educating all people, not just mental health professionals. A lot of the comments in the report so far do relate to emergency departments. A lot of the people who work in emergency departments are not trained in mental health. They are very busy doctors and nurses trying to look after other people and then they have someone saying they are suicidal and they have had five other people come in before them who may not have been suicidal but who may have used that as an intervention, so they do become jaded. I think education and training are needed in relation to what it is we are trying to alleviate for this distressed population. As I said, a lot of emergency staff do not have any mental health training.

Another issue in relation to nursing—I will talk about nursing rather than the medical profession—is that undergraduate nursing training in this country, the bachelor of nursing, does not have adequate preparation in mental health. We know that because AHMAC made the request to the mental health taskforce to develop the report that we are now trying to implement. There is a certain degree of resistance from universities to implementing that report. They are saying that there are conflicting requirements from all other areas of nursing and that if they did that they would have a curriculum 20 years long. The point is that mental health affects everybody, as we all know; I am not telling you anything you don't know. So how do we do that? How do we stop that attitude in relation to people not getting heard and not getting services? Probably by trying to educate everyone in relation to how important it is that there are different levels of intervention that we require.

I know that there are a lot of people who come into hospital and find that there is a real disconnect in relation to how people are followed up as well. People say they are not getting the follow-through or they are not being taken seriously by the health professionals. There is a real disconnect between the notion that emergency departments are a quick fix and, if you have got anything that is going to take more than five minutes to be seen, you are probably not in the right place. But what is the right place for this client population? That is our problem. Emergency departments, at this point in time, are the right place.

Senator MOORE—Particularly at 2 am at night. Where else can they go?

Ms Ryan—Exactly. We do know that a lot of the services that are there nine to five are not there after hours. We do know that in a number of emergency departments they have mental health consultation liaison nurses who are there to provide mental health care, but we also know that a lot of those services are only provided nine to five. We also know that the majority of mental health admissions into hospitals come after two o'clock in the afternoon. So what you have effectively done is provide a service to a group of people who are not there and, when you do have the people come into the hospital, there is no service provided.

CHAIR—Some of the evidence that we have had seems to indicate that Victoria is actually a bit better off in terms of providing mental health triage support. Have you got an indication from the different states about which ones are better and which ones are worse on the provision of services and ER?

Ms Ryan—I would probably say that Victoria is doing a good job. Victoria is doing well on a lot of aspects of mental health, not just that.

CHAIR—That is certainly the evidence that we received.

Ms Ryan—I think we can say that overall Victoria is doing a better job. I probably could not tell which one actually did a better job than the others, but I am happy to get back to you after I find some further information about that.

CHAIR—If you could, that would be appreciated. We are going around to the states, but getting an overall view from a body such as yours would be really useful.

Ms Ryan—I think a lot of it goes back to the commitment of the jurisdictions, particularly hospitals and area health services, in relation to even training the nurses that undertake the triage in emergency departments. We know that there is education and training available—we know that people do that—but whether they actually put a lot of resources into providing that triage service depends on how much of a focus they have on mental health. We know that people still get triaged in emergency departments based on the fact that their leg is going to fall off or something else that we can see, and we know that other patients still sit in emergency departments for a while. I was told just recently by one of the hospitals in Western Australia that patients can still sit in the emergency department for four or five hours, waiting to be seen, if they have a mental health problem, as opposed to the other patients who are in there with a generalist problem—basically because, I would imagine, the triage is not triaging them for their mental health issue; it is still only triaging them for their physical illness.

CHAIR—We will be in WA next week, so we will follow that up.

Senator ADAMS—Can I follow that up while we are on the triage?

CHAIR—Yes.

Senator ADAMS—Does your organisation have any input into the guidelines of triage and emergency departments?

Ms Ryan—We do not currently. They were developed quite a while ago. I do not know whether the organisation did at that time have any involvement in the development of those guidelines. I was not working for the organisation when they were developed.

Senator ADAMS—So what about the evaluation of mental health guidelines for A&E?

Ms Ryan—I have not been involved in the review of those guidelines.

Senator ADAMS—Would you be able to find out if they have been evaluated?

Ms Ryan—Yes. Do you mean the state guidelines?

Senator ADAMS—Yes.

Ms Ryan—There are different guidelines for each state, obviously.

Senator ADAMS—Yes, that is right, and some of the hospitals have their own.

Ms Ryan—Having some nationally consistent guidelines around all of that stuff would be very beneficial, I think—to give people something in terms of consistency. Just because we have different states does not mean that our patients stay in the one state; they move around the country, as we all know—and we will not go down the federation conversation path! But we do know that that has its pluses and minuses for the development of good services for our clients.

Senator ADAMS—I would like to talk to you about Aboriginal health workers. Have you had any success in training up Aboriginal health workers to help with mental health problems in their communities?

Ms Ryan—Aboriginal health workers are trained and they do have some aspects of mental health in their training. One of the things that I spoke about last year, and on which we as an organisation are working with some of our Indigenous colleagues, is trying to develop a framework of core competencies for Indigenous mental health. We need to embed the understanding of Indigenous mental health in mental health curricula, because I think one of the issues we have got is that people think that, because they understand what I would term 'Indigenous cultural safety', they understand how to engage with someone from a mental health perspective in relation to their mental health and wellbeing. We know that is not the case, but, until we do something concrete about embedding that in some sort of curriculum and get people to really understand what that means, we are not going to provide adequate services to our Indigenous population, not by a long shot. And we have only a very small number of Aboriginal health workers, their course is very, very short and the majority of them work up in the Top End.

So there is not a lot support provided from a cultural perspective to that population in our country, and there is a lack of understanding from a lot of health professionals about what that really means. I think they think that acknowledging the fact that there is a cultural difference is what they need to do. But we understand that the treatment of mental illness or mental ill-health in Indigenous populations is very different to how we understand and treat mental health problems generally.

We know that from some of the examples of mental health services that have been developed even in our own region in relation to some of the Pacific islander people. The education and training systems that have been put in place in relation to mental health issues for those populations is very, very different. We also know that New Zealand has done a lot of work in trying to make sure that people actually understand that, and I think that we have got a lot of lessons to learn from New Zealand in relation to how they have embedded those things in their services and the curriculum for their health professionals. We need to do that here and, as I said, we are trying to do that now with mental health nursing, because, as we know, they are the largest population of people that provide services, nurses in particular—and my jurisdiction is nursing, so I will stick with nursing.

Senator ADAMS—Mine was too. We, as a committee, were very fortunate to visit New Zealand two years ago. We were very impressed with the mental health service. They had just released their new framework. That was very beneficial for us, specially doing an inquiry like this now.

Let us get back to the nursing training. As an organisation, have you officially approached the university training schools to register your disapproval that nurses are not being prepared as they should be in the mental health area?

Ms Ryan—Yes, we currently sit on the task force that is implementing the framework that came out of the AHMAC inquiry. We are having a meeting shortly. I think that some of the universities do a very good job in relation to the amount of both theoretical and clinical hours they put into mental health. Some do very appallingly. We know that a lot of it is about the focus

of universities on mental health—whether they have someone in their school who is mental health trained and whether they have an interest in mental health. Whether there is a champion for mental health is often one of the reasons that they do not get mental health in.

We are having a workshop for two days in June, I think, with all the universities that run nursing courses, trying to pull them together to work out what are the issues that prevent them putting mental health into their curricula. We know through the report what should be in the curricula to provide more adequately trained nurses at the end of the day. We know that there are some barriers, but we figured the best way was to get everybody in the room together and try to talk about what are the barriers, learn from some of the examples and give people a bit of a tool kit to go back to their universities and say, 'You can't keep telling me I can't do it because this university has done it and that university has done it.' We are trying to make this a really practical workshop, so people go back to the universities whose heads of schools may not be interested in mental health but which have people who have some skills to try and work with the universities to embed this framework for mental health into their undergraduate courses.

It is not easy and a lot of universities have resisted it for a long time. I think they are understanding more. I think the catchphrase 'mental health belongs to everybody' is starting to wear. I sit in nursing meetings and say to people, 'But we need to put mental health in there,' and they will say, 'But if you want to put mental health in there, Kim, well then we have to put in cardiac nursing and cancer nursing.' I say: 'No, you know that 40 per cent at least of people that have a heart attack are going to have a depression. You know that, if someone has cancer, there is going to be a variety of feelings that they are going to go through and if someone dies they are going to have family left over. You know that, if you are a midwife and a child dies or it comes out with some disability, that parent is going to be distressed. So, no, it is not the same as every other specialty in nursing. Mental health affects every single nurse that is out working.' I think they are finally starting to get that message and that is why some of them are agreeing that it has to go into undergraduate curricula. There is nothing else for it really. Some people will tell us it is resources, but we know that you can make anything happen if you really want it to.

Senator ADAMS—Are midwives getting adequate training with respect to postnatal depression?

Ms Ryan—I would say no, without looking at their curricula. I have had some conversations with the Australian College of Midwives around trying to develop some online courses for them on aspects of mental health. For some of those groups of people we need to provide awareness raising courses if nothing else. We did two education modules a couple of years ago for the practice nurses. They have just loved it, and it has been taken up by a lot of practice nurses because it has given them some confidence to know what they do not know and who they should refer their clients on to.

So that has made a big difference and, as I say, we are currently talking to the College of Midwives about trying to do something for the midwives as well, particularly now that we have got direct entry midwifery, which we did not have until a couple of years ago. We did have midwives that were comprehensively trained—

Senator ADAMS—That was my next question: how did you get on with the direct entry ones?

Ms Ryan—It is different.

CHAIR—I want to follow up on the training issue before I go to Senator Marshall. When you are training as a nurse you do get the obvious training in how to recognise a heart attack and how to recognise other things. Surely you need to have some basic training in how to recognise when somebody has a mental illness or is suffering from depression, particularly if that is what is driving them to an ER. They do not even get that—

Ms Ryan—They would. They all have to have some mental health. I suppose the point is that some universities could have their mental health education in as little as seven day's clinical practice, where others are three weeks. We know that mental health nursing is not the same as learning to do a task which you can do in a simulated environment—which is a lot easier and which a lot of universities do now. You go to a simulated environment and you learn how to do the tasks. I do not know what they do—blood pressure and all the things those nurses do.

Doing mental health means you have actually got to interact with someone. One of the things that is really important in mental health, which we have said in the definition of mental health nursing, is about using self and looking at how you interact with someone. The problem with having very short-term clinical placements, where you may have a clinical placement two days this week and two days next week, is that you have not built a relationship with anyone because when you go back next week the patients are gone and there are new patients.

So they do have to have mental health but there is no particular standard for theoretical and clinical hours. That is what the framework has done. It has said, 'These are the theoretical and clinical hours we think need to be in the undergraduate curriculum to have someone come out with a basic understanding of what mental health and mental illness is'.

Senator MARSHALL—I was just interested in one of the issues you raised under your key issues in your submission—that is, an effective 24-hour telephone service to provide access to support and intervention. You acknowledge the services that other organisations provide such as Lifeline. You talk about the objective of having a service that can provide the caller with urgent access to services or support and intervention. Given the different levels of intervention required, is there a model that you know of that actually works? It occurs to me that with any of this you are going to have people who are simply sad and want someone to talk to. There are people with clinical depression but are not necessarily suicidal, and there are other people who may think they are suicidal or may not even know they are. That is what we are trying to identify.

Is there a system that has different protocols so that we can actually provide a service for those people who do not need urgent access to intervention but who just might need general counselling? Can we provide a service that is staffed by mental health people who can actually do that sort of work properly? It occurs to me that we can provide the service and it does not matter how big that is the demand will just continually increase to fulfil it—

Ms Ryan—It is like hospital beds—you will always fill them.

Senator MARSHALL—and we still cannot get to the people who actually need that urgent intervention. Is there something that actually works somewhere that can actually do that?

Ms Ryan—There is nothing that I know of that works, from how we have described it. Two weeks ago, I think, we met with Lifeline in relation to some of these issues. You are exactly right—if we add another service or just increase the service it would get taken up.

One of the things that we discussed with Lifeline was a process whereby we could escalate the people that ring. For example, with Lifeline, the people that take those calls could assess them and escalate that to the next level so we have a level of clinical intervention, I suppose, in some respects, as opposed to—this is not by any means disrespectful of Lifeline, because they are wonderful—using the word 'counselling' as opposed to 'clinical intervention'. So you have the Lifeline system, but there needs to be another level where it is beyond what those counsellors do and then these people are escalated up to this next level, which connects people to a clinical service.

Two years ago a colleague of mine from the Mental Health Council and I did some modelling—and I am happy to get back to you on that—as to how we would provide a clinical intervention in relation to counselling. Basically we developed that on the premise of rural and remote areas. With a lot of what we are talking about now, we are talking about big city hospitals. In rural and remote areas, they do not have any of those services, even having someone ring up. At least here in the capital cities there is a process whereby, for example, Lifeline can connect you with someone. If you are in a town where there is no-one to connect you to, I am not sure how you get connected to a clinical intervention service.

That was the premise of what we were trying to do with that: trying to escalate it to another level where you could keep in contact with that person. You may have to stay on the phone with that person for hours. You may have to make commitments to ring up every couple of hours. You may ring them the next day. You may get a clinical intervention. It has to be that one step longer in terms of engagement than organisations like Lifeline that are counselling services have. It needs to be connected to community health services and primary care services. We need to have that connectedness, because we are providing a counselling service that is not connected, and it is a counselling service, not a clinical intervention service. So is there a model that I know works? No, unfortunately; I do not know. But we will look into that, and I am happy to send you some information on what it was we spoke about last year.

Senator MARSHALL—I guess the escalation that you were talking about does resolve some of the issues that I had with the general process. Is there nowhere in Australia where we have anything staffed by mental health professionals in any form of escalation at the moment?

Ms Ryan—We do, but most of those services are provided through area health services or jurisdictions. I think one of the criticisms that we received from nurses in the submission was that a lot of those are manned during the day, and they are not manned during the night. If they are manned during the night, they are dispatched through to an emergency department, for example, and there are no mental health staff there. So it goes back again to the fact that a lot of services that we provide are provided from nine to five, and we know that that is not when people access services.

We also know that some of those telephone services are provided by people that already work in busy mental health units—for example, admission wards—or crisis teams, so the issue is their ability to consider, 'Do I sit on the phone with this person for an hour'—which is completely

justifiable—'or do I have to go out and see this person?'—which is also completely justifiable. So a lot of the after-hours phone services are patched through to other services that are being provided. These people are then in conflict as to which one they do, because they obviously cannot do both. So it is not providing dedicated telephone intervention counselling services. At night-time, they are relegated to a lot of other services. I understand that, but I think that it will be the case whilst we continue to do the work we do on a jurisdictional or state based level.

That is why some of the nursing lines have been successful. There is a nursing mental health line in Victoria and there are the general nursing health lines. They are helpful because they are not just about one particular jurisdiction that cannot afford to fund a particular service. So, if we could come up with something that was a national service—it would not matter where you were; you could ring some place and get some sort of assistance, referral and connectedness—it would be really important, I think, because we know that a lot of times people that are depressed, suicidal or distressed do not sleep, and at three o'clock in the morning they decide they want to talk to someone, and they do not talk to someone. We need to get past the point where there is no-one available for them to talk to or they get told to go back to bed because they should be asleep and that is going to be good for their mental health as well—which is true to a point.

CHAIR—We have heard a lot of evidence around online support from Inspire, particularly with a youth focus. Have you been involved in those sorts of online services at all? One of the issues that came up is that people can access those services at any time and there is the very point that people will sometimes go online at night. Do you have any comments on that?

Ms Ryan—I do know about some of those services. In some respects a lot of services go back to this level of service here.

CHAIR—Which is the counselling?

Ms Ryan—Yes. We need to provide services to the next level which is really about the intervention. One of the concerns I have in relation to a lot of policy documents is that we continue to talk about suicide prevention—which I think is a wonderful thing—but we do not talk about suicide intervention. We are trying to get people to understand how to engage with people who are suicidal. If I ask you, 'Are you suicidal or have you ever thought of suicide?' and you say, 'Yes'—do I know what to do with that? A lot of people do not ask the question because they do not know what to do with the answer and that is where we run the risk of having people who are not trained appropriately trying to get that person engaged in appropriate services. That is where we have 25 per cent of nurses who are working in health that are not mental health nurses asking the question or not asking the question as the case may be. Whether or not you are a mental health nurse if you ask someone whether they are suicidal and they say, 'Yes, I am', that is the issue. I think a lot of people do not ask because we talk about prevention but we are not teaching people how to provide the intervention. When someone says, 'Yes I am suicidal', how do I engage that person in the appropriate services? What do we do with that? How do we support them to be able to say, 'Yes, I am suicidal' and do something about it? Those services are great but I think they provide this rung that we were talking about earlier and we need to try to provide some more 24/7 true intervention services.

Senator ADAMS—I am looking at page 9 of your survey about collaboration with groups. I am interested in that everything else is up around the 50 per cent level and then at the bottom we

go to 14.9 per cent on the Other category which includes religious workers, community aged care services, homeless agencies and homeless workers. I would have thought that group being so vulnerable would have been a very good group for health professionals to be working with because possibly a lot of their clients who turn up at A&E would be coming from those particular areas. Can you explain why there was such a small response to that?

Ms Buck—I think what you are seeing there is merely the way a survey works in capturing a response. The way that question was put to the nurses was, 'Do you want to collaborate more with any of these groups?' We listed all of those groups down to community organisations and then we asked whether there were any other groups that they would like to work with. A few nurses responded with homeless agencies and homelessness workers. As you see, there is already a category in the list around housing services and so there would be nurses who would say that they would like to collaborate more with housing services and under that umbrella would fall homelessness shelters and things like that. If you look at the list, the organisations like the community organisations, the housing services, Centrelink and the youth centres show that the mental health nurses actually see that their role and their work involves collaboration beyond the healthcare system and with the whole social support system.

Senator ADAMS—It is a very good list. When I read it I thought it was excellent.

Ms Buck—Yes. They would like to do more, and I think it is really important that they see that they do need to collaborate more with the police. Given the role the police play with people who are suicidal, I think it is key to find a way to build better relationships between mental health nurses and police. I would say that what is really coming out of the response to that question is the need for the nurses and the police to have an understanding of each other's roles

Senator ADAMS—Speaking of the justice system, are they employing more mental health nurses within the justice system, especially in the residential areas?

Ms Ryan—I do not know about the residential areas. They are employing more nurses. Some of the corrections health services now have people like court liaison nurses. That is about trying to really keep those people connected, out of the court system and into appropriate mental health services. I think the justice system—with all due respect to it, it is a very difficult place to work; I have worked there—have done a lot of work in relation to mental health over the years. They have still got a bit to do, I would have to say, but they are getting better.

Senator ADAMS—There are all sorts of areas and layers of residential. Coming back to rural—I know we have got our rural expert waiting to give evidence in a minute—what communication do you have with your mental health teams in rural areas, and are we attracting more people out there to work in that field?

Ms Ryan—Are we attracting more mental health nurses to rural areas?

Senator ADAMS—Yes.

Ms Ryan—Not particularly.

Senator ADAMS—Are you doing anything to do that as an organisation?

Ms Ryan—There is little we can do. What we try to do is to provide support to the nurses who are actually out there. It depends on where they are in rural and remote. Steve will know more than I do about rural and remote. Darwin, I think, has got plenty of nurses, actually, but they come and go. They are not there for a long time. As far as supporting people to stay in rural and remote areas, basically what we try to do is support them to be there. There are a variety of reasons why they do not go there—least of all anything that we can influence, which is things like salary, wages and conditions. Support is a big one in relation to people not going out there. We can only do so much, but I am sure you are all aware of the reasons why people do not go to rural and remote places.

CHAIR—We will follow that up further with our next witness.

Senator MOORE—Can we get an idea, on notice, about the spread of your membership? You gave us a little blurb at the start about what you do; but, considering Senator Adams's questions, could we get an idea about the spread of the rural and remote membership and also whether you have got anybody in the residential part of the justice system.

Ms Ryan—I will be looking up that one.

Senator MOORE—It would just be interesting to see, with the people who have chosen to be part of your college, with the expectation that mental health is the major focus in their training, where they are spread. That would be useful.

CHAIR—Thank you very much.

Ms Ryan—It is a pleasure. We will get back to you with that information.

CHAIR—Yes. We have given you quite a bit of homework.

[2.13 pm]

SANT, Mr Steve, Chief Executive Officer, Rural Doctors Association of Australia

CHAIR—Welcome. Mr Sant, I know you are seasoned in terms of appearing in front of committees, so I am sure I do not need to go through the full blurb—but I will because I am supposed to. I believe you have been given information on parliamentary privilege and the protection of witnesses and evidence.

Mr Sant—Yes.

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

Mr Sant—The first point I want to make is that our submission was written by Libby Davies, who is our policy adviser, who has now left to go and live in Sydney. I have been left to try to do justice to her work. It was also done fairly quickly, because our staff is very small and we have been trying to respond to a lot of committee submissions lately, and health reform things—

Senator MOORE—Mostly for us, Mr Sant.

Mr Sant—I might just make a few key points. You probably already know this, but suicide rates in rural Australia are significantly higher than in metropolitan areas—in the order of 1.2 to 2.4 times higher. That is possibly being underreported as well, because our members believe that some of the single motor vehicle accidents—which also occur at higher rates in rural Australia—may also in fact be suicides rather than motor vehicle accidents. So there may be some underreporting there. Whilst suicide rates are higher, mental health prevalence rates are about the same, and there is not any significant difference. That leads us to a question. We are getting a worse outcome but the prevalence is the same. There is something there that does not gel.

In many rural areas, mental health is a lot more visible in the community in that you are in a very small community and everybody knows when you have got a mental health issue—and that is not always the best way to encourage people to get treatment. We, with our colleagues in beyondblue and Tim Fischer—who you would know—made a community service announcement about 18 months ago, trying to raise the profile of mental health and getting people to say, 'If I do feel a bit down, then it is okay to go to my doctor and talk to them about that issue.' One of the big issues we are got is getting men into their doctor. Blokes in the bush seem to be much worse than others at this.

It will not surprise you to know that our major issue is workforce. We do not have enough access to services in rural Australia—mental health services or any services. There are not enough doctors One in 10 GP encounters, as I understand, are related to mental health. So, if you cannot get into a GP, you cannot get that issue sorted out. Another issue that I am a little bit reluctant to raise is that we have a very large number of international medical graduates in rural Australia. They span a great spectrum of some very competent, very good and experienced international medical graduates through to some who are probably less so, who do not

understand particularly well the culture of Australia and, in some cases, do not understand the language of Australia and vice versa. To some extent, there is a lack of tolerance there as well on the part of some of the people in the bush.

We have no access to specialist services as a general rule. Around 90 per cent of psychiatrists are located in the city. So you have got 10 per cent serving 30 per cent of the population. Along with that, we do not have enough psychologists, social workers, mental health workers, mental health nurse—you name it, they are lacking. So it is really hard to put together a team when the team is nobody or one person.

There is also not a great understanding of mental health issues in many areas of government or health. I will give one example that sprung to mind with the National Health and Hospitals Reform Commission, who started putting together performance indicators around mental health. They really largely overlooked the high prevalence disorders and the primary care part of that. The high prevalence disorders being the great bulk of 90 per cent of mental health disorders are usually treated in primary care and general practice. So even in the National Health and Hospitals Reform Commission—which is a very learned group of people—they missed a significant part of the mental health puzzle. I think we sometimes focus too much on the hospital treatment of the other disorders, not the psychosis and those sorts of things; whereas a great bulk of mental health issues are the high prevalence ones—the anxiety disorders, depression and those sorts of things. They clearly are a big issue in rural Australia.

I do not know whether I need to go too much into recommendations, but I think there are two things that we have to do. We have been spouting on about a rural health obligation for a long time, so that people can understand what sort of access they should be getting to services in rural Australia. I should be able to get access to focused psychological strategies—CBT or whatever—in the bush through my general practice, through a psychologist who visits, through an online service or whatever and we should be able to access shared care arrangements for those more complicated cases that really are beyond the capability of general practice so that, while people may live in their rural community, there is a clinical network or a shared care arrangement for the care of those people with a specialist psychologist, psychiatrist or whatever in a major regional centre. If we address the workforce issues, we will go a long way towards addressing the issues in mental health and a lot of other areas.

The final thing is that all policy initiatives should be looked at with a rural lens. We call it ruralproofing. We get sick and tired of saying, 'In the city A + B = C, but in the bush it does not equal C at all; it equals D, E and F and it may have totally the wrong outcome to what you are expecting.' I think we should be testing every single health policy initiative against that rural lens.

Mr ADAMS—I could not agree more.

CHAIR—You can go first, Senator Adams.

Senator ADAMS—Would you explain your health obligation to rural people?

Mr Sant—We put it together a couple of years ago, and it was sort of modelled on the Telstra community service obligations, saying: 'If I live in a rural community, I should be able to expect

to receive these sorts of services'—and these are things like obstetric services—'so I should not have to travel more than X minutes to get to an obstetric service. I should be able to access mental health care in terms of a general practitioner who has experience and training in mental health and can provide me with things like cognitive behavioural therapy and that sort of stuff.' It is really not rocket science. It is just saying that here are a set of standards which the great bulk of Australia should be able to access. We are not asking for an acute psych unit in every single small rural hospital because that is not possible, but we are saying that we need some capacity to treat at least the high prevalence disorders and to have a process in place for dealing with the other disorders.

Senator ADAMS—Coming back to rural communities and their access to a GP full stop, if a GP has their books closed for three weeks, you may have someone with acute anxiety who turns up to the emergency department and you have a volunteer ambulance driver and you have no staff from the hospital to take them anywhere—there are all of these sorts of issues. There are practice nurses in a number of the medical centres in which GPs are trying to get a multidisciplinary team around medical services; instead of having a solo GP they are getting two or three in a practice if possible. Is there any training for these practice nurses that would be of use?

Mr Sant—Yes. I know that a lot of the divisions have done training around things like mental health first aid and some other mental health training to try and bring up the skill levels of those practice nurses; we certainly support that. But, again, it is fairly sparse, and it is getting a nurse who is in the back of beyond somewhere to a place where they can do some training without any funding or support. Nursing is peculiar like that; they expect the nurses to do it in their own time with no pay or, even worse, to take a day off work. That is a really difficult situation for them, so having access to training courses would certainly help.

Senator ADAMS—With the foreign-trained doctors coming from Western Australia, most of our outer rural areas have people who have come from every other part of the world except Australia. Probably one of the biggest problems for the patient is that they finally get there and then cannot understand what is being said to them. I have found that that has been the most frustrating thing: people have finally got someone to go, they get an appointment and they get there, and they come out and they are completely and utterly frustrated and their anxiety has been made worse by that. What training or orientation is given to these people before they go out into those areas?

Mr Sant—It varies but, as a general rule, very little. There are many stories around of a doctor turning up in a town with their family, taking one look and turning around and walking out again. That is an area where we really let our international medical graduates down. We have often said that we put the people who need the most support into those communities where they get the least support, and that is a real problem. We do not support the 10-year moratorium anymore. We believe that we are putting people into communities where they cannot undertake safe and quality practice. They are at risk, the community is at risk and it is clearly not a good situation.

Senator ADAMS—How are you going with the rural generalist training?

Mr Sant—Queensland are going gangbusters. Queensland have a great training program based on the ACRRM curriculum. I understand that Western Australia have been looking at it; I do not know that anything concrete has come out of that yet. Certainly we see the results of that sort of training program in Queensland, where they are getting the doctors out there and providing them with support, and they are staying. There are a whole lot of factors to that, but it clearly works.

CHAIR—What are the additional resources that are being put into that Queensland program?

Mr Sant—There are a number of things. One is they are paid like a specialist: they come out of their training program and they are paid at the same rate as a specialist in Royal Brisbane or wherever. That is a recognition of the additional training they do. Another is that there is a career path for them. Even if they leave rural medicine they are recognised within the Queensland system as having special skills and there is a career path that they have been developing in areas like emergency medicine where there are places in some of the bigger hospitals for these rural generalist doctors. There is good training support and there are things like time off. They know they are only going to do 21 days, which might sound like a lot of time, and then they are going to get a week off. Having that sort of certainty around time off is really important, particularly for work-life balance, as is getting time off to do training and time off to take annual leave and not having to run a practice with all the overheads associated with that—to the extent that we occasionally hear of private practice doctors saying, 'Maybe I'll do this because I'm sick of having all those overheads of running my practice and not getting time off and I can never get a locum in to support me.' So it is a combination of things. There is a very strong training program through the ACRRM curriculum as well.

Senator MOORE—There has been a major resource dedication from the Queensland budget. We can follow that up. There are also the links that those doctors have with any other doctors in the region, so there is quite a strong focus on networks. I have visited a couple.

Mr Sant—Yes, they all know each other and there is a very strong network. They turn up every June at the RDAQ conference and greet each other like long lost cousins.

Senator MARSHALL—You said they are paid as if they are a specialist at a city hospital. What would that rate be?

Mr Sant—Off the top of my head I would not like to quote it. I have a feeling it is around 300 and something thousand. There is a package of things put together. I would have to get you more information on that.

Senator MARSHALL—Thank you.

Senator MOORE—One of the things this committee looked at in previous inquiries was training on mental health for any doctors who are already in service. One of the things that were promoted was the Better Outcomes package, which was giving people real incentive for training—although some of us had some concerns about how much training was involved. Does the Rural Doctors Association have any data on the number of your members or the people who choose to be your members who have taken up the extra mental health training?

Mr Sant—No. The divisions would have that data, so AGPN would probably be able to provide that to you.

Senator MOORE—I was just thinking about that from the rural perspective. We spoke with a number of doctors and with the people who are running the training and I was just trying to remember what the geographical spread was of people who chose to do that. A lot of it was driven by someone really pushing it in a region. We will follow up on that. The other thing we talked about was the program for flying professionals into different areas—is it ASOP?

Mr Sant—MSOP.

Senator MOORE—Yes, that is right. I always forget my acronyms! MSOP seems to be the only current program for psychiatrists to come into regional Australia. Do you have any feedback from your members about the effectiveness of that program?

Mr Sant—They certainly support the program, but I rarely hear of psychiatrists.

Senator MOORE—They talk about surgeons.

Mr Sant—That is right, and paediatricians, general physicians and those sorts of things. I am not aware of any psychiatrists. I am sure there are.

Senator MOORE—We will check with the Department of Health and Ageing about that. I know that in previous inquiries we heard about the use of MSOAP to access psychiatric services. One committee member in our previous term had a particular issue about the number of psychiatrists in capital cities as opposed to the country. Not one inquiry went past where she did not make note of that. I feel a need to just put that on the record for her even though she is no longer on the committee.

Mr Sant—There is a joke going around in New South Wales that you can see every psychiatrist's home from the telecom tower in Sydney. I do not think that is too far wrong.

Senator MOORE—It is not too far wrong; it is the same in Melbourne. The previous witnesses talked about the idea of the telephone service and put on record their view about the need for an enhanced telephone service so that no matter where people lived they could get in contact. We know the Lifeline services are there in phone books for the first round. Does your organisation have a view about the idea of an enhanced telephone service that would give more specialised support if people had to—

CHAIR—They called it 'intervention'.

Senator MOORE—Yes, provide intervention as opposed to counselling?

Mr Sant—No, we do not have a formal view. I know you talked about online services with the last witness and I know there is quite a bit of evidence showing that those services can work, even the interventionist type ones. I think some work was done around that at the ANU recently. We would certainly support any of those services, be they telephone, online or whatever, but

nothing beats having a person who can direct you to those services. The face-to-face stuff is irreplaceable.

Senator MOORE—Does the Rural Doctors Association have a mental health strategy or policy?

Mr Sant—We do not have a specific one. We certainly include it in our rural health obligation, but no we do not have a specific one. In fact, we do not have specific policies for most of those clinical areas. We leave that primarily to our colleagues in the colleges.

Senator MOORE—Sure.

CHAIR—You talked about the higher prevalence—1.2 and 1.4—in rural areas compared to urban areas. I strongly suspect that you are right in terms of the single motor vehicle accidents. When the updated ABS data come out—it was supposed to come out last Friday, 19 March, but it has not come out yet—I suspect it will show an even greater differential. Have doctors in your association noticed an increasing trend? What are your members saying about the trend?

Mr Sant—We are not getting any feedback that it is getting any better or any worse. They are saying it is fairly critical now. It would be very hard to actually spot a trend in a small community where you might have one suicide every X, Y and Z months.

CHAIR—What about people visiting their GPs and raising mental health issues?

Mr Sant—Again, they have not indicated it is any more frequent. I noticed you said three weeks; I have not spoken to any of our rural doctors lately where it is anywhere less than about four to six weeks wait.

Senator ADAMS—That was Katanning, but there are five of them so that helps.

Mr Sant—Yes. The other point too is that it is the same person who walks out of their general practice into the hospital.

CHAIR—Which brings me to my next question which is about the lack of support services available when people are released from hospital after having been admitted for a mental health illness or after a suicide attempt. This is a problem in Western Australia in a couple of towns and we have had it reported to us in other places as well. Even in an urban environment that support is not there let alone in a regional or remote area. Have your members commented on their ability to support people once they come out of hospital?

Mr Sant—Yes. It is absolutely true that that happens. At least in urban areas, there is a population size that can support some service, whereas in most small or rural communities it is so small that you cannot support a mental health nurse or a special service. So it is a real issue, particularly with those people who may have been admitted, say, to a major psych unit in the city. They come back out to the bush and there is nothing there for them. They rely on their general practitioner, but that GP is busy, they have to get their throughput, they have people on their waiting list to come and see them, they cannot spend an hour and a half or two hours sitting

down with a patient, they have to churn them through to make sure they see everybody on the day. It is a real vicious cycle for those people.

CHAIR—The issues around workforce come up throughout your submission, but there is also the issue around the rural specialist training. I am pretty certain we will be making recommendations in our report about work force not just in the regional areas but in the urban areas as well. You heard the mental health nurses association talk about the lack of training for nurses as well. What would be your key thrust? We only have a few recommendations we can make, because we all know that the government pays attention to a certain number. What would be the key workforce issue you would suggest we should make a recommendation about? Would it be around the rural specialist training programs and providing more of that?

Mr Sant—Certainly, having access to psychiatrists in rural Australia would be good, but most centres would not have the population to support them. I think that having high-quality training available to our general practitioners is important. Again, not to degrade the work that our IMGs are doing, but if we can get more Australian graduates out there—who have gone through the Australian system, who understand the cultural issues, who have had some reasonable mental health training in the course of their undergraduate training and some reasonable mental health experience in the course of their prevocational training—that would be ideal. But mental health is not really valued in that training, particularly as an intern and beyond that. It is a really critical area that you have to have experience in. It is probably the second most prevalent disorder we see in general practice, but it is given pretty short shrift in the hospital system. You have your surgery rotation and your medical rotation et cetera. It is not a key area that is recognised.

Senator ADAMS—I wanted to ask you about dual diagnosis and how your doctors are dealing with that.

Mr Sant—It makes the process that much more complicated. They are no different to their colleagues in the city. It is a very difficult issue to deal with—the addiction issues and a mental health problem. I really do not have an answer for you.

Senator ADAMS—Right. I will not go on any further on that one. I could give you a lot of demonstrations of some of the problems—

Mr Sant—They often seem to go together.

Senator ADAMS—They are hard in the city, but you can imagine what it is like when you have five or six of them in a small country town and the GP is trying to deal with them all.

Mr Sant—Yes. And especially if they come from India or Sri Lanka or Ethiopia and they are not even familiar with the—

Senator ADAMS—That is right. I am looking at your shared care arrangement. How do you see that—as a Medicare item? How are you getting along with that?

Mr Sant—Medicare is one thing—and there are some items there that allow mental health consultation and that sort of thing—but it is really about having the clinical networks in place in the states so that the GPs in country towns know they can access that expertise, so they can refer

on to someone and so that that person at the other end of the line also knows what the capabilities are in that particular town. Other members of the team can be involved—psychologists, social workers, housing workers or whoever it may be. It is really being able to slot someone in to that supportive network. Medicare is just a payment mechanism. It is really about having the clinical networks in place that is important.

Senator ADAMS—Can I keep going?

CHAIR—You can ask another one.

Senator ADAMS—Mr Sant, the third issue you raised was about all policies having a rural focus. How are we going to ensure that that happens? It is very difficult in Canberra to talk about rural hospitals. Wagga, Mackay and Townsville are viewed as remote rural hospitals and, along with the sorts of hospitals or health services that we have in WA, they can be closed down. But people live there, and they have to have access to medical services somewhere. Is your policy—because you will be asked, or I hope you will be asked, for input into policy, perhaps by both the major parties—saying how it should be done? Can you give us an idea of how you think it would work in a perfect world?

Mr Sant—Firstly, you have to have a recognition that rural is different and that something that works in a bigger regional centre or a city may not work in a small rural centre. In fact, it may end up being a greater problem. I can highlight numbers of issues—and not necessarily mental health ones. One that we were dealing with this week was around midwifery. In rural hospitals, most women are admitted as public patients. Midwives can only claim when those patients are admitted as private patients. When a rural GP admits a patient as a private patient, they lose a lot of money because they have normally got an arrangement with the state government as a VMO. It means that we now have a positive disincentive for rural GPs to work with midwives, even though they may wish to. They may wish to collaborate and do all the things that we have been talking about. However, if it is going to cost me $300, $400 or $500 then that does focus my attention a little bit, because I am not only a rural clinician, I am a rural business person. No-one in government understood that when they made this change. We certainly supported the antenatal and postnatal care but we never recommended intrapartum items for that reason. That is just one of so many examples of where we do not understand the impact of policy on rural Australia. We go ahead and implement a policy and then something totally unexpected happens from the government's point of view. If they had sat down with the rural doctors—not me, but people who are out there in the field—and said, 'What happens if we do this?' they would have said, 'We need to do something different here.' That is our key point: understand the consequences of your actions in rural before you implement any policy or change there. The Office of Rural Health is, I am afraid, not doing that. It has not been one of the things that they have done at all well. In fact, to be frank, I think they have stuffed it up. We really want to see a particular focus in government on rural and an understanding in the bureaucracy of, in particular, how we develop policy, what the impact of policy is on rural and making sure that cabinet and government are aware of those things before they make decisions.

Senator ADAMS—Thank you.

CHAIR—Any other questions?

Senator MOORE—Judith, we are happy for you to continue. This is your area.

Senator ADAMS—Thank you. Let us get down to Aboriginal medical services and the link there. Do you have much to do with our Aboriginal medical services?

Mr Sant—We have members who work in them. We have a lot of members who visit them. Rather than being permanently located in a service in a small community, they will visit there. Yes, we have quite a few. They tend to be employed district medical officers rather than employed doctors or anything else, but they are a significant part of our membership, particularly in the Northern Territory and WA.

Senator ADAMS—As far as mental health services go, do you include rural doctors in any of your workshops or anything like that to bring them up to speed?

Mr Sant—Yes. As members of the Rural Doctors Association of Australia, ACCRM, the Australian College of Rural and Remote Medicine, or the RACGP, they can access those workshops, so they are not specifically excluded. We do not run a lot of specific Indigenous mental health workshops. I do not think we run any. Our focus has tended to be around the traditional sort of clinical procedural type workshops, and we run those. Mental health workshops are not an area that we have particular expertise in.

Senator ADAMS—In Narrogin, in Western Australia, 12 young men committed suicide within three or four months. I know that the rural doctors there were absolutely traumatised by that. What backup would your organisation give them?

Mr Sant—We would give them backup through our state bodies, and often it is through peer support. But one of the most important backups around is the CRANA Bush Crisis Line, which all the health professionals can access. We would certainly support that service continuing to be funded, and expanded, and made available across the whole range of professions.

Senator ADAMS—Would your state organisations be prepared to put locums in there so that the resident doctors could have a break? How do you work in that situation?

Mr Sant—State organisations are part-time committees of rural doctors. We have four staff Australia-wide, and they are all here. So that is not really an option. And most of our members in the rural communities are pretty overworked themselves, so there is not a great deal of capacity for them to go out and do locums. In Queensland and a couple of other states the executives of the committees spend a lot of time talking to their colleagues who have crisis issues—be it mental health issues or other issues—and trying to support them. The strong networks of doctors in towns works quite well.

Senator MOORE—Do you have any data on rural doctors who commit suicide?

Mr Sant—No; and, surprisingly, I have not heard of any.

Senator MOORE—I am just wondering whether that is a dataset that is kept or whether those people just get swallowed up in the normal stats. It is certainly something we have talked about with the stress of people working in rural and remote areas and also people from professional

backgrounds. There are stats about particular professions having a higher likelihood than others of committing suicide. So I was just wondering whether that dataset is kept.

Mr Sant—I am pretty sure we would hear about it.

Senator MOORE—On the grapevine.

Mr Sant—Yes, because the networks are so strong. What we hear is that people give up and say: 'I'm not going to do this anymore. I'm going to the city. I'm going to get into a nice office practice or become an anaesthetist or whatever.'

CHAIR—Thank you very much.

[2.48 pm]

HAYES, Professor Alan, Director, Australian Institute of Family Studies

ROBINSON, Ms Elly, Manager, Australian Family Relationships Clearinghouse; and Research Fellow, Australian Institute of Family Studies

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

Prof. Hayes—The focus of our submission is around the sorts of factors which increase the likelihood of suicide, particularly in those who have been bereaved. We also look at a number of initiatives that target those who are particularly at risk and the identification of high-risk groups. We also look at the implications for research and what we would see as some of the priorities for research. We can provide extra copies of two of the background documents that we used as a basis for this submission. We can supply, in PDF form, copies of the earlier work that the institute did in the evaluation of the National Youth Suicide Prevention Strategy. There are about six volumes of that. Unfortunately, we have run out of print copies but I can get you PDF copies.

CHAIR—Thank you. Ms Robinson, do you want to add anything?

Ms Robinson—Not at this stage.

Senator MOORE—Professor Hayes, in your submission you have listed a lot of additional resources and papers that have been written. Is it correct that the major work your organisation has done in the area of suicide is the review of the Youth Suicide Prevention Strategy?

Prof. Hayes—Yes, it is.

Senator MOORE—Have you been requested by government to do any other major work in this area?

Prof. Hayes—Not in this area. Although we do of course have a growing interest in issues to do with families and mental health, alcohol and substance abuse and violence. So we are interested more broadly but we have not been asked to do work specifically on suicide.

Senator MOORE—We have talked before in different inquiries about the work you have been doing in those areas you have ticked off. Has suicide been a focus, or is it more on the side?

Prof. Hayes—In recent years it has not been a specific focus; it comes up in the course of other work. We have done a collaborative project with ANU around relocation disputes. Unfortunately, one of the participants in that project was murdered and we are aware of others who have suicided. But it has not been a specific focus.

Senator MOORE—That could be one area we could look at. One of the things we have talked about with you before is the effective use of your organisation and bringing it into the mainstream of consideration. One of the core issues many people have referred to in their evidence is what I call the viral aspect of suicide—that is, so may times we have a case of suicide, brought on by whatever, and then in a short period of time there are a number of other cases. A real understanding of that phenomenon is something that we and the community are struggling with. Are you aware of any studies that look at that aspect?

Prof. Hayes—Yes. I will ask Ms Robinson to respond.

Senator MOORE—Ms Robinson. I knew you were aware of other studies, but I just wanted to get it on record.

Ms Robinson—One of the papers we looked at was around 'suicide postvention'—how suicide identifies vulnerable families not necessarily through the act of a family member committing suicide but because it identifies a range of factors which are happening within that family. And that, combined with the grief, stigma and shame associated with a suicide within the family, often leaves the family particularly vulnerable. That is an area in which a limited amount of research has been done. We thought it was important to cover that within our submission and identify some of the areas where there were gaps in research around that at the moment.

Senator MOORE—The aspect of the intrafamily process has come out in numerous submissions and stories about families that are so damaged by a series of events. There is a community aspect. Particularly in rural and remote areas, and not only in Aboriginal communities—but there has been a focus on Aboriginal communities—are you aware of any more focused research? I know you have identified that, but are you aware of more work in that field?

Ms Robinson—I am not aware of suicide work specifically but there has been some work done at the Australian National University around rural and remote areas and mental health.

Prof. Hayes—We have done some work looking at the impacts of climate change and drought in areas of Australia. That work highlighted the extent to which mental health problems, including those that end in suicide, are a major issue for many rural communities. I think the spillover or viral effect is particularly important. In this submission one of the things I found very concerning is the increased probability that the relatives of people who suicide, particularly the children, will themselves suicide; that risk increases. So there is a sense in which this can have intergenerational impacts as well.

CHAIR—I just wanted to go to the issue of research that has been done, specifically in Aboriginal communities. I think it was the Australian Indigenous Psychologists Association who raised the issue. They were calling it 'contagion'. I hate that expression. They indicated they thought that there was an increased rate in Aboriginal communities. It sounds like you have not done any specific work in that area. Would I be correct in that?

Ms Robinson—There are definitely statistics that show that it is more prevalent within Aboriginal communities and families. One of the things that we did look at within the paper on postvention was that there was very little work done within Aboriginal communities and families

around postvention in terms of the things I talked about before and the amount of risk that brings up for families and communities. I think that is an important gap within the literature as well.

Prof. Hayes—I think it is a part of a cluster. Understandably, your focus is on suicide, but it is a cluster of other behaviours that have other outcomes. An Aboriginal woman is 35 times more likely to be hospitalised than a non-Indigenous woman. The rate of substantiated child abuse is six times higher for Aboriginal children, so I think it is part of a cluster. I do not like the word 'contagion' either but there is a sense in which it is a phenomenon. I think there is a reasonably well established pattern where the event of suicide then triggers a similar behaviour in others and in small communities its impact can be devastating.

CHAIR—We received evidence in Darwin—in fact it was in one of our other inquiries with the same committee about a month ago—that an average Aboriginal person would suffer 12 traumas in their most immediate community compared to one or none for non-Aboriginal people in the same period of time.

Prof. Hayes—That is right.

Ms Robinson—Considering the strong links between mental illness and suicide, some of the factors that happen as a result of trauma and post-traumatic stress disorder and the impact they will have on individuals, families and communities will in and of themselves increase the risk of suicidal behaviour.

Senator MOORE—The other thing I just want to touch on briefly from your perspective is the data. We had extensive evidence in Queensland about the different ways that particularly child suicide is identified. It is not just the ongoing aspect of what is suicide and what is not, which continues to cloud the debate; it was evidence that said that different jurisdictions had identified different age groups. Whilst of course we would hope that there would be very few children under the age of eight, that would be identified in this area. That comes back to accident or suicide. There still was not a standard youth suicide database done by all the states. Is that something that your institute has looked at?

Prof. Hayes—No. We have not explicitly looked at that.

Senator MOORE—I know you struggle with these issues all the time with the work you do.

Prof. Hayes—We have looked specifically at issues to do with the lack of harmonisation of child protection statistics. We are particularly focused on that and sexual assault statistics but not suicide per se. There are some touch points to work on child death but that is not a major focus that we have had.

Senator MOORE—Have you actually had any success in that harmonisation focus that you have talked about in so many of your papers?

Prof. Hayes—I think we have worked fairly heavily to provide background material to ministerial councils and we had a lot of input towards the preparation of the National Framework for Protecting Australia's Children. We assisted FaHCSIA with that. But we have not specifically focused on suicide since this work.

Senator MOORE—I am sure one of the recommendations would be about data. There always is one.

Prof. Hayes—Yes.

Senator MOORE—In terms of the work with child safety, has a national dataset for child safety been achieved across all the states in the framework?

Prof. Hayes—My understanding is that there are solid moves towards that. There is progress being made towards that.

Senator MOORE—We will check with the ministerial group. I just wanted to see whether that had been successful because it would be a start. If they harmonised that dataset it would not be that difficult to move on.

Prof. Hayes—My understanding is that currently it has not been achieved but progress is being made towards its achievement.

Senator MOORE—Positive steps are being made towards it?

Prof. Hayes—Yes, exactly.

Senator ADAMS—Regarding the data and research, Ms Robinson, which part of the world would be most useful for us to look at? I am going through your list of all the different areas and each country. Which country's framework would you say has been successful and useful for us to consider?

Ms Robinson—I am not well familiar with the lot of the countries' frameworks. I know that work has been done in areas where research often happens, such as in the UK and the US. I think that Australia itself has a very good framework in the LIFE, Living is for Everyone, framework. That is a very good basis on which to start work. It addresses a lot of the issues in terms of how difficult it is to pinpoint the people who are going to suicide as opposed to looking at a range of risk factors that lead to that. It also looks at the way that services can respond using both universal and targeted, selective intervention. That means whole population approaches to pinpoint areas of prevention and early intervention, as well as targeted high-risk groups—we mentioned some of those in the submission, including Indigenous communities and the like—and targeted aspects, particularly for people who have been in psychiatric care or have left inpatient admission when they have been exhibiting suicidal behaviour. They are the two areas that are particularly high risk, so programs can be targeted through them. I would say that Australia has a very good framework in that respect.

Senator ADAMS—Have you done any work on older people, perhaps in the farming community, in rural areas? Is there anything there that you know about?

Ms Robinson—Yes. We looked at mental health problems and people from rural and remote areas accessing help for that, particularly men and help-seeking behaviours. One thing that comes out of the literature is that men are much more likely to be stoic about what is happening with their mental health. They are much more likely, particularly in rural areas, to get on with the

job, because often there is no-one else on the property who can take over for them. They tend to get on with it, move on, pick up the pieces and be practical about it. It is quite clear from the mental health literature that help seeking is an issue to be addressed.

Senator ADAMS—Looking at finances, this year is probably going to be a really bad one because the banks are starting to tighten up. A lot of farmers have quite large debt and crops fail, and now it looks like they will not be able to borrow money to put the next crop in. Have you heard anything feeding back from that at all?

Ms Robinson—No, not that I am aware of.

Prof. Hayes—That was a focus of the work that we did in drought affected communities. Again, we could supply copies of the literature to the committee. Often the triggers were around financial difficulty. It was an interesting study because you could contrast those who are on farm with those who are off farm in the same communities—you could unpack some of the issues associated with those who were involved in farming as opposed to those involved in the support type industries in the community. In terms of success, you would have to say of the initiatives that took place in the latter part of last century and the early part of this century that a halving of the rate of male youth suicide since 1997 is a fairly dramatic impact when considering the peak levels. One statistic that was far from flattering was that we had the highest rates in the OECD at one point, I think.

Senator MOORE—It is really terrifying.

Prof. Hayes—It was appalling.

Senator MOORE—Those figures just forced action to be taken.

Prof. Hayes—I think your question about older Australians is another issue, because when you look at the acceleration of the probability of suicide by decade of life from 65 onwards there is a real concern about that too. In some instances there are complex explanations for it, but I think there is a sense in which you do have some indications of the way in which you can proceed. The LIFE framework, which you are all more aware of than I am, is a good example. So I think there are things that we are doing here that are actually being looked at by others as leading the way in terms of the rate of success in addressing the male youth suicide rate.

Ms Robinson—There was a study in Queensland done by Stephen Morrell that looked specifically at the National Youth Suicide Prevention Strategy, as to whether that had an impact on youth suicide rates, and found positive evidence that it had. That is a good example of something that has been put in place in this country and has seemed to work. I am happy to pass that on if that is of interest. I think, as to what will happen, that the LIFE framework is a reasonably new document, as is the new national suicide prevention plan, so once we know what will happen in a similar way the evaluation of those programs will give us a good idea about how effective the framework has been.

Prof. Hayes—Coming from the recent experience of completing the evaluation of the family law reforms, we do see, whether it is us or others, how important it is to really systematically

evaluate some of these initiatives and to look at how they are implemented and what impacts they actually can have on the statistics.

CHAIR—Which leads nicely into a question I have around family relationship services. In fact, I was just about going to hand over to Senator Marshall. We have now had the centres in place for quite a period of time and you talk about that specifically in your submission. I am wondering if you have had any interaction with the centres and what response you have had in terms of suicide issues coming up and counselling that is available for clients and also for staff in terms of mental health training.

Ms Robinson—I have not specifically had conversations beyond personal, off-the-record conversations with people around what is happening within the organisations. There is constant evaluation going on with some of their programs, and I am aware of one that is happening in the Drummond Street Relationship Centre—which is in Victoria—looking at their family mental health support program and the outcomes of that. I am not sure whether they look at suicide and suicidal behaviours specifically, but they certainly look at mental health outcomes. I think the beauty of one of the things that they have done is to reverse the normal trend of looking at risk factors for mental illness by looking instead at protective factors and risk factors as to mental health. I think that is a growing trend that is very positive for service provision.

CHAIR—Are you or anybody else undertaking any research with the centres and with Family Relationships Services Australia?

Prof. Hayes—We have just come from their CEOs meeting in fact. That is what brought us to Canberra. Yes, they were heavily involved in the evaluation of family law reforms and we are looking for ways by which we can continue to follow the developments there. One of the addresses that we heard today was by Professor Richard Chisholm, who did actually touch on suicide as one of the factors around risk to children. In other words, our evaluation and his evaluation focused on family violence but, in terms of mental health impacts on children, suicide or the threat of suicide can have very profound impacts leading to outcomes like anxiety and depression and also, as I said before and as our submission says, leading to an elevated risk of suicidal behaviour or self-harm.

CHAIR—So that research is being undertaken.

Prof. Hayes—We have done that research as part of the evaluation and we are seeking to continue to work in this space. It is one of the priorities within our research plan.

CHAIR—I understand you have done the family law research but I am thinking of linking it specifically to the issue of suicide and how you would evaluate that. Was that included in your research?

Prof. Hayes—Mental health was, but not suicide.

CHAIR—Is there any ongoing work about suicide?

Prof. Hayes—We are keen to continue that work because really what you see, as I said, is that toxic triangle of violence, mental health problems and substance abuse and they seem to go

together as a package. Of course suicide is one of the more probable outcomes, as is family violence and as are transmission of mental health problems to children and other members of the family.

Senator MOORE—What is your funding? You had a key role in the whole family law change, both leading into it with the panel that was doing that and then evaluating the first 12 or 18 months—whatever it was.

Prof. Hayes—Really, it was a three-year project, so from just before it was implemented—

Senator MOORE—Where does it go now? Where does your funding cycle on that go?

Prof. Hayes—Where it goes now is that we are applying for other contracts and commissions. We have some irons in the fire around some evaluation of some of the initiatives that are flowing in the family law area. As you would be aware from my other appearances in other contexts, we have about 30 per cent of our funding from the appropriation, which in real dollar terms is shrinking because of the efficiency dividend and other things that are the realities of life. The other 70 per cent we raise through competitive bids for tenders, for partnerships with universities and other players around ARC funding or NHMRC funding—although we cannot be directly funded from that—or commissions from government.

Senator MOORE—So you are part of a partnership? So if someone has a major body of work—

Prof. Hayes—Yes. For example, we tender for work a lot with the Social Policy Research Centre. We will do work with some the non-government organisations—that is an increasing area of work for us. We do some work for the states and territories. For example, with the Social Policy Research Centre we are designing the evaluation framework for Keep Them Safe, which is the New South Wales state-wide initiative in child protection. We are bidding for some work around the area of out-of-home care and highly vulnerable populations of those who are in out-of-home care, often as a result of family mental health, violence or substance problems. So yes, this is an area that does really concern us but it is not one in recent years, since the earlier work, that we have been funded to look at.

CHAIR—I just wanted to follow up a specific issue there. In that research you are doing, will you be looking at children who are in out-of-home care who have been subjected to violence in the past and their long-term mental health issues?

Prof. Hayes—It is a longitudinal study. It is not finalised yet, but the New South Wales government is interested in our involvement in that project. We have had a long involvement in an advisory role. They have put it out to tender twice. They have put it out for tender for the second time and we are very interested to be involved in that.

CHAIR—Will that include looking at the provision or lack of provision of long-term support for those particular children as they grow older?

Prof. Hayes—It will indeed.

CHAIR—It is a particular passion of mine.

Prof. Hayes—And it will look at those who are leaving care and what happens. For the first time I think we will have a fairly large database around that and I think that will be very useful.

CHAIR—This is just New South Wales, though, isn't it?

Prof. Hayes—It is in New South Wales.

CHAIR—Are you doing any similar sort of work in any of the other states?

Prof. Hayes—No. We do child protection work in other states—

CHAIR—But I am after that specific work.

Prof. Hayes—but not that specific one. That is for the New South Wales government.

Senator MARSHALL—I may have missed this in your submission but I am just wondering whether you have got any stats around suicide that involves physical harm to others, whether it be fatal or otherwise, and the extent of that part of the suicide equation?

Ms Robinson—So murder-suicide situations?

Senator MARSHALL—Yes, or attempted murder-suicide or harm.

Ms Robinson—Not that I am aware of, sorry.

Prof. Hayes—No, we do not. Again, it is a very important area to untangle because it is often the sort of event that occurs, for example, in circumstances of family separation and divorce. But it is not one that we have looked at. We have to strongly prioritise what we look at because we are a relatively small organisation. I think that is a really important area.

Senator MARSHALL—Sure.

Prof. Hayes—And it is quite often difficult to predict the occurrence of that. I think that is the area that also needs a lot more consideration—the fact that, as we say in the submission, there are many people who do not present with a background of mental health problems, or they are not obvious to others, but then catastrophic effects flow. That is one of the issues among rural communities—men who are regarded by those around them as operating quite effectively who then, to everyone's surprise, suicide.

Senator MARSHALL—I guess when it involves others the damage and effect is exponential.

Prof. Hayes—Absolutely.

Ms Robinson—It may be worth mentioning that I have worked on a program with the Australian National University that looks at the family law system and the way that deals with

mental illness within families who access the court and the family law system more broadly. That was an area that was neglected for some time. The project looked at ways the family law court could address those issues and implemented a mental health pilot program within the family law system that has continued. So, in terms of the links between mental illness and the particular area of separation and the mental health aspects of that in and of itself—the stress of being involved in family breakdown—that is better recognised within the court system now.

Senator MARSHALL—How long has that been going for? I know that you are not necessarily an expert on this—you referred to the study—but is it too early for an evaluation to have been done on the effectiveness of the changes?

Ms Robinson—I think they have done an evaluation of the pilot program. Whether they have done further evaluations on the rollout from there, I am not too sure. I am happy to look into it.

Senator MARSHALL—Yes. If you could just send us a note on that report, we can look it up ourselves.

Senator MOORE—I am just interested in two organisations we have heard of and know get federal funding and what your link is, if any, to them. One is the Australian Institute for Suicide Research and Prevention at Griffith University. You have mentioned ANU a number of times. We have not been able to meet with the people from Griffith yet because of timing and so on. Just from an outsider's point of view, an organisation at a university with that title would be seen to be for suicides as you are for family processes. We will have to have that confirmed when talking with them, but that is what you would expect. Do you have links with them?

Prof. Hayes—Do we have any?

Ms Robinson—I am aware of their work. They have existed for some time but I have not worked with them formally.

Senator MOORE—The other group we heard about that we have not been able to meet with either for different reasons—although we are hoping to at some stage—is the CSS in Melbourne.

Ms Robinson—The Crisis Support Service.

Senator MOORE—Yes. We are told it has been funded to have a kind of central database for what is going on in suicide and what services are available. Have you had any interaction with them?

Ms Robinson—Yes. We have regular interaction with the Crisis Support Service. Their research and evaluation team is on the reference group for one of the projects within the institute. They let us know quite regularly the work they are doing. I am not aware specifically of work they are doing around suicide and mental health at the moment, but they do have a strong program in research. They look at the calls that come through MensLine and the issues that men contact the service for.

Senator MOORE—That is in their general service delivery aspect—

Ms Robinson—Yes.

Senator MOORE—and their research but, in terms of this particular focus on suicide, that is not something that you would be involved with?

Ms Robinson—I am not sure.

Senator MOORE—Can you check that out to see? One of the terms of reference is research in the area. From looking through the funded processes in the budget, we see pages from the department of what they were funding. That is very useful because we have not had that before. I usually carry the book around but I have forgotten it today and I do apologise. They are the two that I thought had a focus on research. We are just trying to touch base to see how they interact with other organisations.

Ms Robinson—Yes.

Senator MOORE—Thank you.

Senator ADAMS—My questions were going to be based around rural issues, but I think we have probably covered that. In that area at the moment with depression and not being able to have access to a GP or just not being able to admit that things are wrong there is quite a large cohort that needs to be looked at. The other issue is with youth. Their starts look good but just from our evidence you really do wonder about these straight roads with one single tree just what is going on with the car crashes. It is really sad. You do not want to paint the picture too much but it does happen an awful lot and you do wonder why.

Prof. Hayes—We have not done research on that specifically, but I do think that is an issue. There are often community pressures to mask the fact that it was suicide. I freely say that that is anecdotal but, having grown up in rural communities, I know there can be a sense in which cohesiveness can also be a little dysfunctional.

Senator ADAMS—It certainly can, like when a visiting mental health nurse comes on whatever day and people drive past to see whose car is there. Everybody is identified by their car number—you know who they are. So you find that they will be moving away to go to a larger area and go through the emergency department or through outpatients and you think, 'Crikey, what's going on?'

Ms Robinson—Something that still exists very clearly within the literature is the stigma associated with both mental illness and suicidal behaviour. Places like beyondblue have done great work in reducing that stigma, but particularly in rural areas—

Senator ADAMS—It is very hard.

Ms Robinson—I think you have nailed it in terms of confidentiality and the issues around that, and people 'getting on with it', the stoicism that I talked about before.

Senator ADAMS—Also, people do not want to go to their local doctor. They try to get access to another doctor somewhere and there is a waiting list a mile long so they cannot get in. It is not easy.

Prof. Hayes—I think it is another area where education and information programs are particularly important. But I also think there is a sense in which—correct me if I am wrong—some of the work with young people is around protective strategies and about admitting a problem early so intervention can occur. The problem with this is that depression particularly is so insidious in that it carries with it protections. People will not speak up because part of the driver is all their thoughts about being inadequate, insufficient and incapable, so it self-perpetuates in the way that I think Senator Moore's comment about it being viral referred to. There is a viral aspect to mental health.

Senator ADAMS—Certainly.

Prof. Hayes—There is that insidious nature, but often if you can get people to support early—

Senator ADAMS—The other thing is postnatal depression, with a lot of mums, especially first mothers, going home very early now. There is such a difference just in the first 24 hours they are out and they have a child. How do they deal with it? Before, they had a week and by that time, if there was a problem, it was picked up and they were able to deal with it. Once again, it is so hard for them to get help and often it is too late. Problems have arisen before anyone has really recognised what is going on.

Prof. Hayes—That is right. I think some of the trends in family statistics are interesting, because at the turn of last century basically the average household size was 4.6 and now it is something like 2.6. The largest growing household type is a person living on their own. A lot of these things are problems exacerbated by detachment from other people and detachment from supportive networks. You find that both in cities crowded with people—but people so lonely and isolated—and in rural locations where people may be isolated by their own sense of not being willing to disclose.

Ms Robinson—Could I also mention that the institute recently wrote a research paper looking at online counselling and therapy and how it is showing promise sometimes for some people who it suits, particularly people in rural areas, young people and men because of the anonymity that is available in using that medium. It is an area that is showing a lot of promise and I think there is scope for further research into that.

Senator MOORE—What was the stimulus for that research?

Ms Robinson—It was looking at what some of the options were for people who were unable to access face-to-face services. That is a growing area and the paper was looking into the research behind the evaluation of those services.

Senator MOORE—That was from your core funding?

Ms Robinson—That was one of the papers that were written by the Australian Family Relationships Clearinghouse, which is part of the institute.

Prof. Hayes—But it was not part of our appropriation.

Senator MOORE—It is very relevant, because we keep hearing about this and I was unaware of that paper.

Ms Robinson—I can send that one as well.

Senator MOORE—The idea of online counselling and phone counselling has come out consistently and it is in some of the key recommendations from the larger umbrella groups. It would be very useful to have a look at that.

Prof. Hayes—The funding for the Australian Family Relationships Clearinghouse is under a contract, so it is not part of our core funding. We live in hope that it will be continued, because it is a fairly important area, and the uptake and use of the web resources with it has been very pleasing—largely thanks to Elly's energy and talent. It strikes me that that is an area that is so important. Getting information out to professionals is the other thing. The AFRC—and I do not want to give it too much of a plug—is all web based, so professionals all over the country have access to it. We think there is a lot more that we could do through it in highlighting issues like suicide postvention and responses to family violence. There is a Domestic and Family Violence Clearinghouse at the University of New South Wales and we work closely with them. The rule we apply is that it should have a family dimension to it, so we avoid the clinical but we look at the family and community context. Forgive my digression.

Senator MOORE—In another inquiry that we are doing on hearing, we heard from the Menzies Research Institute about a similar model looking at hearing services. Do you have any knowledge of that? Is there any cross-professional awareness of how these things work?

Prof. Hayes—No.

Senator MOORE—I just thought we would try to touch on those because, from the way you have described it, it was a very similar process.

CHAIR—Yes, auspicing it.

Senator MOORE—Yes, the web based services.

Prof. Hayes—I am aware of the work of Professor Gavin Andrews, I think it is, at the University of New South Wales, where they have developed a very effective suite of online counselling programs particularly targeted at young people and particularly focused on anxiety and depression. Anxiety and depression are rapidly increasing in prevalence among young people—dare I say to epidemic proportions. There seems to be much less stigma in accessing those things. Of course, you need to rigorously evaluate with whom they work and for whom it should not be indicated or recommended.

CHAIR—There are no further questions. Thank you. It is very much appreciated. And we have given you some homework, I think.

Prof. Hayes—Yes. If there are any other papers in our submission that you would like copies of, we can send them through as PDFs as well.

CHAIR—Much appreciated. Thank you.

Proceedings suspended from 3.28 pm to 3.44 pm

YATES, Mr Ian Garth, Chief Executive, Council on the Ageing National

ROOT, Ms Josephine Mary, National Policy Manager, Council on the Ageing National

CHAIR—I welcome representatives from COTA National. You will have been given information on parliamentary privilege and the protection of witnesses and evidence. We have your submission; thank you very much. I would like to invite either or both of you to make an opening statement and then we will ask you some questions.

Mr Yates—Thank you, Senator, and thank you for the opportunity to meet and have some discussion of our concerns around suicide. COTA National, as you would know, is the national policy arm of the eight state and territory councils on the ageing in every state and territory, obviously. We are the only peak ageing consumer organisation and, through our extensive nationwide organisational membership, we represent more than half a million older Australians in addition to tens of thousands of people who individually belong to COTAs in different states and territories. I am the chief executive and Jo Root is the national policy manager, and I would just acknowledge that Jo is the principal author of our submission, which does however draw on experience from around the COTAs. Our focus on national policy issues is always from the perspective of older people as citizens and consumers, and we seek to promote, improve and protect their circumstances and wellbeing. We use our extensive national network to collect information and views from across our membership in developing policy positions and submissions, and that applies to this one.

As outlined in our submission, our particular interest is in the suicide of older men, who have a high rate of suicide—and that rate increases with age. We believe that older men need to be identified as a high-risk group that needs some targeted programs as well as enhanced access to mainstream services. Any work to reduce suicide among older men needs to include the following. Firstly, the evidence shows that the vast majority of older people who completed suicide suffered from depression, so there is a clear need for better diagnosis and treatment of depression in older people. We think there need to be strategies to combat the ageist view of many health professionals that depression is a normal part of ageing, and therefore it does not get addressed. These strategies include ensuring that the curriculum for all health professionals' training includes more on how to diagnose depression in older people and what interventions work.

We also need to combat similar views in the broader community and among older people themselves. In that context, COTA is delivering the Beyond Maturity Blues project in partnership with beyondblue. It is a peer education program we referred to in the submission, with older volunteer peer educators talking with community groups. This has been very successful in raising community understanding of depression and the ability to identify it. We have now had 2,002 community sessions delivered, with an estimate of over 40,000 participants by the end of February this year. The latest results—with beyondblue we monitor outcomes from it—show that the number of people who could correctly identify depression rose from 28 per cent to 70 per cent after receiving the education. We think that indicates that there could be a broader community awareness and federal professional education campaign.

We also think there needs to be better training for all health professionals and aged-care workers about the life events that can be triggers for older people's suicide, how to talk to people about them and where to refer people to for help. Given the evidence that older men are more likely to succeed when they do attempt suicide, early intervention that identifies people at risk is critical. There needs to be an integrated set of services for people identified as being at risk to be referred to. All adult public mental health services should include older people in their client group. This may mean looking at special measures to ensure access to services, including transport—which is a key issue for older people in accessing any health service—and the design of buildings, and ensuring some expertise in the particular needs of older people is included in the skill mix of the service.

Finally, another important element of the early intervention model is more effort on initiatives that help reduce the social isolation of older people and in particular older men, or, to put it in a more positive way, to promote their social inclusion. Across the country there are a number of programs which could and do help reduce social isolation, but they are often piecemeal and not connected to each other and they do not have clear referral pathways to services that might provide further help or in fact to themselves. There needs to be a more integrated approach to linking such services and more effort put into identifying people who are isolated or at risk of being isolated and finding ways to encourage them to participate. Obviously, we believe the peer education model being used in the Beyond Maturity Blues program could be used to assist with identifying and assisting people who are socially isolated.

I might just say that the Beyond Maturity Blues program has now, with our latest initiatives with beyondblue, been extended explicitly into other language groups—Italian, Greek and Vietnamese in particular at the moment—in our community, and we are very excited to say that we are just initiating a pilot program dealing with Aboriginal older people and depression.

That concludes our opening statement. We would be happy to discuss any aspect of the submission.

CHAIR—Ms Root, did you want to make any opening comments?

Ms Root—No, thank you.

CHAIR—We will now go to questions.

Senator MOORE—Mr Yates, your submission talks about the program, Beyond Maturity Blues. We have heard about it before. Your funding goes until June 2010, according to the submission. What should happen next?

Mr Yates—Firstly, we are in negotiations with beyondblue about that, and certainly we expect the culturally and linguistically diverse programs to advance—and, as I just said, we have been pleased to just reach agreement with them on a pilot Aboriginal program. But their concern is that they are not set up to be a long-term funder of programs; their aim is to demonstrate something. So we are together trying to look at how we can attract resourcing of what has been proven to be a successful program in an ongoing way. To be frank, we are struggling a bit to get the attention of the health authorities to do that. But we think—as we have said in our submission and our opening statement—that really people ought to be looking at these basic

community programs. They are not terribly expensive. Predominantly, the personnel in this programs are volunteers. You obviously need people to train them and people to coordinate. There are quality-control issues. But we have found them to be very successful.

Senator MOORE—Can we get some information from you about the cost?

Mr Yates—Certainly.

Senator MOORE—You have spoken about how many people, you have estimated, have been able to go through the program; that it is done by trained peer educators; and its impact. It would just be useful to see what that has cost, to now, and also to get some idea about what should happen next. You have made the point—which is often made—in the submission about the stop-start nature of processing. There has really got to be a more visionary, long-term process, rather than the short stop-start process to which you refer. So that would be very useful.

From a general point of view, within your organisation—which operates right across the country and has people coming together at different times—what importance is given to the issue of suicide, in all the other things that your organisation looks at in terms of the issues facing older Australians? I know that, as an organisation, you have identified suicide amongst older men as a priority. But when your members talk and when they put forward what is important to them, how much priority is given to suicide in those discussions?

Mr Yates—My answer would have to be, obviously, anecdotal—

Senator MOORE—Yes, absolutely.

Mr Yates—and Josephine might want to comment as well. Of the generations that we serve at the moment—and we serve more than one—the older generation, in particular, would be reluctant to have those conversations. That is one of the strengths of the Beyond Maturity Blues program: there is more conversation elicited. A side benefit has been that having the programs operating in the COTAs around the country has enabled people working in other programs to have those conversations. When you have bright posters saying, 'Talk about depression,' and resource materials about it, that enables people to take it as a more normal conversation. So, for example, it might come up, in a program that is working with seniors clubs on a range of other things, that this is part of the initiatives that we offer, and so we will talk about it.

But that generation is generally reluctant to talk about suicide and is reluctant always to acknowledge it when it occurs. And it is reluctant to talk about depression. In many cases people believe that they have just got to get themselves together and get through it and do not recognise that it is something that, as with any other health challenge, they need assistance with. That would be my general comment.

Certainly outside the metropolitan area there is a kind of cloak of silence around talking about completed suicides. Of course the families are not keen to have that conversation, so that is part of the issue that we have. That does not mean that people do not know about it. Certainly we find in the beyondblue sessions that there is a responsiveness—people know what we are talking about, although they have not had a conversation about it.

Ms Root—It does come up in forums that we hold, particularly in rural and regional areas. Queensland COTA have reported that it comes up more often when they are out and about talking across Queensland, as you know they do. It comes up particularly for people living in rural and remote areas, because there is a double edge, I guess—older men having a higher rate of suicide generally and then the higher rate of suicide in rural and remote areas. A lot of that is men, with the drought and with a whole lot of things. So it does come up in conversation and has been fed back to us as an issue of concern. It still is very much stigmatised. In death notices when somebody commits suicide, it is never put that they commit suicide. It is 'unexpected death' or something like that. You might get a clue because it might say, 'donations to beyondblue rather than flowers', which is the kind of link. You can understand why people want to do that. I guess that is part of our culture, but it does come up.

Senator MOORE—I know Senator Adams will take up the rural issues. The only other question I have is about how much, if any, discussion there is by older people who are part of families who have seen their young people suicide. We have had a number of submissions and some evidence about the survivors, the families of people who have made that choice or taken that decision. I think there are issues around family support, if you have not been actually yourself thinking about it, which is one focus of the beyondblue sessions, I know. I am just interested in the, I imagine, quite special impact if a young person commits suicide—particularly on their grandparents. It seems to me to be a cultural area that we have not talked about a lot. Has that come up in your discussions?

Ms Root—The whole issue about support for families after a suicide has come up from a number of COTA clubs, forums, or however you want to describe it. It has also come up in the context of Aboriginal communities. I did some work in Yarrabah. You probably know Yarrabah's sad story of suicide as well as I do. They are the older people. They just do not understand why this happens. They felt powerless, but they actually did take action in Yarrabah and it was led by a group of older people. The intergenerational impacts and probably the support for families do come up. People just do not know where to turn for help. I think that is possibly the case.

Senator ADAMS—This is a question I have been asking most witnesses. It is really about the older farming community people, mainly the males, going back to the fact that, when they finally feel they want to get help, of course the GP has a huge waiting list. The other thing is that they do not want to see the mental health nurse when she or he comes to town, because their car would be identified as being there on that day. Consequently they try to take themselves to larger regional areas where they will not be known in the same way. It is that hard bit that, when finally they realise something is wrong—and probably they have not told their wives or their family—they just go off and see whoever it is and then they cannot get there and problems arise. I come from rural Western Australia. COTA is very active in Perth and in a couple of the larger regional areas but, other than that, we do not have that organisation. Do you do work through Rotary, Lions or Probus? Do you have any connection in that respect?

Mr Yates—These kinds of peer education sessions are run through all of those kinds of groups and we advertise them to those networks. We have put a lot of emphasis on trying to get outside metropolitan areas with this program, with a great deal of response. The points you make are really valid. To some degree you cannot turn them around easily because, as you say, people do not want to be identified. A key part of what we do—so it is not just the sessions themselves, and it is promoting them through our magazines, through our other activities, through seniors

week activities and through those kinds of things—is talking about a program on depression as one of a number of things that we do, so not to overemphasise it but not to underemphasise it either. So it is about saying, 'Hey, we do something on the quality use of medicines and we do something on depression' and on other subjects. It is an attempt to normalise conversation, but it depends on whether the person belongs to any of those groups. We do promote and advertise. I would have to check as to Western Australia, but I know that in a number of states there is take-up from those kinds of service networks. That is a good question and we could follow that up. It would be good to get those kinds of service organisations to actively pick up these issues.

Senator ADAMS—Another area is probably bowling clubs.

Mr Yates—Yes. We do certainly target those.

Senator ADAMS—I am going through the different things in the towns that I am very familiar with. It really is hard, because what has been happening is that of course the average age of a farmer is now much older and younger people are not coming back to properties, so these people, these men, are probably becoming more and more isolated. They should be retiring but, unfortunately, they cannot because there is nothing else there or else they have to sell their farm and then you get that loss as to what they then do. There are some really good community initiatives but not everybody goes to them. It is about how you identify those persons. Your organisation does a great job in the city—I have been to a number of its meetings—but I think there are so many people missing out.

Mr Yates—I would acknowledge that across the states and territories we have at present different capacities outside the metropolitan areas. There are some COTAs that have significant programs outside the metropolitan areas. Jo has already instanced COTA Queensland. On any particular day that I contact their chief executive he is more likely to be in a regional city than in Brisbane.

Senator MOORE—I do not think he would serve much time in Brisbane at all.

Mr Yates—A large number of programs in South Australia, for example, are run, quite deliberately, outside the metropolitan area. There is an extensive network of member clubs across the state. That is less so in the west, so I would agree. I think the other issue that we face in the country is people's respect of each other's privacy. It means that they do not necessarily inquire of each other, 'Are you okay?' or that they do not inquire very far. We need to address that. I do not have any quicker answers than you would have probably had from other witnesses.

Senator ADAMS—It is a culture. I think it is something that is the last bastion of that strong Australian male that is the protector and the provider. Things have changed a lot in the city with the younger generation, but it is that older group that tends to be missing out. The wives are off doing all sorts of things. The men are becoming deafer and deafer. Once again it is that age group that have hearing impairments, not from the banging and the racket of all these hi-fi things that go around, but from open cabin tractors. There is quite a cohort of those sorts of people.

Mr Yates—We would certainly acknowledge that. We are conscious that in rural areas farming communities are a significant part of our direct constituency because of the age groups that they are and because they face those challenges. I would agree with that. We try with the

resources we have to reach out to those communities, but it is difficult. It is an area that does need specialist attention. I think the other thing—and this is anecdotal; I do not know how you would really find it out—is that there is indeed a belief that in country areas there is some underreporting of suicide and that in particular certain vehicle accidents are in fact suicide. But how do you prove it?

CHAIR—The comment was that for older people there is a higher number for men, which is the same across the demographics—it is males that more successfully complete an attempt—but it is women who attempt more suicides. Is that the same for older Australians as well? Are we seeing the same statistics for older Australians as we are seeing across the demographics?

Ms Root—I would have to check that. I am not entirely sure. I do not think it is but I will need to go back and check the data that we have. Certainly we know that men are more successful, because they have the means. I will need to go and check that and I can send it to you.

Senator MOORE—It does seem to be linked to methodology. The end result is often determined by the method used.

Ms Root—Absolutely.

CHAIR—If the same holds true for older women, we would obviously also need to be targeting programs at older women because, if we know there are a lot of attempts out there, we also know that is associated a lot with depression. I am wondering whether we need to be targeting programs around depression to older women.

Senator MOORE—There are a lot more out there too.

CHAIR—There are a lot more of them as well, as Senator Moore has just pointed out. There are a lot of older women out there too who may also be suffering from significant depression that we may be not picking up.

Mr Yates—Certainly in the submission—and Jo might want to comment on this—we highlighted the fact that the actual completed suicide rate for older men is high. In the programs that we are running, we do not differentiate. In fact, the major recipients of those programs would be older women because they are the large proportion of the population and they also tend to attend many of those activities and groups.

CHAIR—I suspect they are also the ones who egg on their partners to come to programs as well. Particularly if they find them useful, they may then want to encourage their partners to attend as well.

Mr Yates—That may well be.

Senator MOORE—Are there any gender based ones? People have variations of models. Have COTA and beyondblue looked at running men-only or women-only programs to see whether there is a particular take-up? I do not know. I am just wondering if that has occurred.

Mr Yates—I would need to refer you to beyondblue. I think they do, but they should answer that. In this program, we have not specifically. Some of it would happen because of the nature of the groups that we are presenting to.

CHAIR—That is all right. We have been talking about male farmers and I completely support Senator Adams' comments and line of thinking—that there is a cohort of men out there that do need specific targeting. There are programs in WA. We have Pit Stop and a couple of others that are specifically targeted at men. They need to be. I am just wondering: would we then need to be targeting programs at a specific cohort of older women or not?

Ms Root—I think the evidence on social isolation suggests that more men are socially isolated than women. More older men are socially isolated. In the work that they did in Queensland, the Queensland government did a very good study on social isolation. In the work done in WA by COTA WA in conjunction with the WA government last year, older men were targeted as needing more direct intervention. Work is the focus of their lives and once they stop working they lose a lot of their networks, whereas a lot of older women have been at home for longer and so have a much broader group of networks. This is not always true but generally the data suggests that. So you get initiatives like Mensheds—

CHAIR—That is exactly where we were going next!

Senator ADAMS—What about the funding for them?

Ms Root—Mensheds is, I think, a really interesting development that can get men into groups. There are other activities in Home and Community Care. There are things like men's cooking classes, which serve two purposes. They help older man to cook and feed themselves so they do not have to get Meals on Wheels but they also get them into a social group. So they work doubly.

I think one of the things that we would like to see is programs like Home and Community Care doing things that promote social inclusion, not just meeting an individual's support needs with direct care but actually getting them out, because teaching somebody to cook is much more beneficial in terms of interaction than taking them meals into their own home. We would like to see more of those kinds of mainstream programs having a think about how they could just change their model to meet some of the social isolation issues.

As Ian said, women tend to turn up to peer education sessions. I have not seen the data, but I suspect more of our peer educators are women than men—but we can certainly check that. You are probably missing the target group to some extent unless you can find a way to get men to come along to them. When you go to men's sheds and have a discussion about depression and about suicide, those men have built up trust, so you can get them to talk about it much more than in a group. I think the idea of a single-sex thing is something that we should perhaps talk to beyondblue about, and we should have a think about whether that might work better.

CHAIR—I know Senator Adams has a question on the tip of her tongue about funding, but, when Senator Adams was talking about organisations you work through, it sounded like you are working with men's sheds as well. Would that be a correct assumption?

Mr Yates—Yes.

Ms Root—We would be working with anybody who has links into the community. That is the model that we are using. We are not just talking to our own members with Beyond Maturity Blues; we are offering a service to as many organisations as possible—

CHAIR—To as wide a range as possible.

Ms Root—and trying to get it out there.

Mr Yates—And that includes the men's sheds movements and Older Men: New Ideas programs in some states and so on. One of the more general comments I make is that we really need to address ways of promoting social involvement more broadly in the community. We tend not to think it as important in older people but it is actually crucial to inclusion and engagement, and it is really easy to slip off. It goes to that image we have of life having some kind of 'best by' date or that after a certain age you are past it. It is really critical to provide those channels of inclusion because people feel that their roles have been lost. People feel invisible. That is a very common phrase that older people will use. It is about creating opportunities, not opportunities to keep amused but opportunities to keep contributing and being involved. People do not commit suicide usually and do not get depressed and do nothing about it if they actually feel they are making a major contribution. There are exceptions to that, but the isolation develops when you do not feel that there is much reason for you to be around anyway.

CHAIR—Just following up on your comments around social inclusion: how engaged have you been with the government's Social Inclusion Agenda?

Mr Yates—To date only marginally, but in fact we are just approaching the Social Inclusion Board to suggest that we might have a formal conversation about the issue. For us—and we could talk about this for a long time—it is a vexed issue. It has two sides to it. We do want to promote the social inclusion of older people in our community. There are many groups which are the target of social inclusion initiatives which have older people within those groups, and that is fine—

CHAIR—Yes, so they are being included there.

Mr Yates—but the issue of older people is complex because it goes to some very fundamental assumptions about ageing and older people that challenge broad social norms. So we are keen to have a conversation with the Social Inclusion Board now that they have done some of their other things, and we have been actively talking with the parliamentary secretary's staff about this quite recently. We are keen to start that dialogue. There is a dilemma for us in classifying all older people as socially excluded. It is a two-edged sword for us that we are working through as well.

CHAIR—There would probably be similar issues with other cohorts of people as well. Just saying, for example, 'All disadvantaged people are socially excluded,' does not hold water either. I am not trying to minimise the comments you have made, but I suspect it is an issue that needs to be dealt with for a group of people, so it is an important point to raise.

Mr Yates—Yes. It is a very significant proportion of the population. It is not the same proportion, but there are some similarities with the issues of the changing roles of women in society over last century, for example—exclusion and inclusion.

Senator ADAMS—Can you give us any indication as to what is happening on the men's shed funding? Have you heard anything about it?

Mr Yates—No, I am not up to date with that. I do know that some people have struggled and that the issue we raise in here of stop-start funding, which we could raise across a whole range of positive initiatives in health promotion and illness prevention in our community, is one that bothers us all the time. For example, we have another program, which is called different things in a couple of different states—'Living Longer, Living Stronger' or 'Strength for Life'—which promotes older people being engaged in strength training, not just aerobic fitness. The research evidence on this is really strong. In fact, it is a very effective addressing of depression. We have struggled in all places to maintain funding for that kind of initiative.

One of the dilemmas is that you go to health departments' promotion areas for funding and they are the poor cousin in the big funding arena, and then they put the pressure on you to make this sustainable. Frankly, when your target group is pensioners, it is very hard to make this sustainable unless you find someone else to fund it for a while, and then you have to call it something else or badge it as something else. People do not understand the dilemmas that creates in outreach into the community. We have managed in some states to run the same program for quite a few years, badging it as or calling it different things, but it is not ideal at all. Then, every now and then, you have a break and get three years of funding and think, 'Wow!' The evidence is there and it works, but you cannot get commitment to do it. We would have fewer people in our hospitals and acute services if we put more money into those programs.

Senator ADAMS—That is exactly right. There are savings.

CHAIR—That is what I call sustainable. Keeping people out of hospital is sustainable.

Mr Yates—Absolutely.

CHAIR—Sorry; I am preaching at you.

Mr Yates—We are agreeing with each other vociferously.

Senator ADAMS—Yes, we are.

CHAIR—Do you have another question, Senator Adams?

Senator ADAMS—No, not really, but I think the organisation is doing a great job. We will certainly do our best in trying with our recommendations to influence what is going on, because time and time again you have very successful projects and then, when the three years are up, you lose the key people that were working in them. It is such a waste.

Mr Yates—Absolutely.

Senator ADAMS—The saving to the health system is huge.

Mr Yates—Absolutely. Thank you, Senator. That is a real challenge that we face regularly: you do not know if the funding is going to be renewed, and you understand when your staff leave, and then the funding is renewed.

Senator ADAMS—That is right. And then what do you do? They are gone.

CHAIR—You have to start all over again.

Mr Yates—Yes.

CHAIR—Thank you very much. We very much appreciate it. We have had a lot of submissions about young people but not so many about older people, so we really appreciate the time that you have given us to talk about it.

Senator ADAMS—I have been raising older people—

CHAIR—I know you have. I am not saying it has not come up; I am saying we have not had a lot of submissions.

Mr Yates—We will certainly follow up the points that were raised. If in the preparation of your conclusions and report there are other questions, please do not hesitate to be in contact with us. Jo Root is based here in Canberra, but we are accessible at any time.

CHAIR—Thank you very much.

[4.19 pm]

HOCKING, Ms Barbara, Executive Director, SANE Australia

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

Ms Hocking—Yes.

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

Ms Hocking—Thank you. I appreciate the chance to be here. I was fascinated, listening to the last witnesses, actually; I would have been interested in listening to everyone. You have all received the initial submission, and there is a second one that has come through which is our research bulletin. There are three main areas I do wish to speak about today. First of all, I will give you a little background on SANE Australia for a start. We are a national mental health charity working for a better life for people affected by mental illness—that is all mental illnesses and all age ranges. We are not specifically looking at any one particular diagnostic group or age. We are much more concerned about the impact of mental illness on people's lives.

There are really three areas we work in. Firstly, education—that is, developing education resources and programs to help people understand and make sense of mental illness as a first step to coping with it. There is also applied research, such as the research bulletin that you have seen. That is research that is going to make a difference to people today: while we are waiting for the medical researchers to come up with the cures in 20, 30, 40 years time, there is an awful lot that we can do today. Then there is our campaigning-advocacy work, which is campaigning for improved services and support and, probably most importantly of all, improved attitudes towards mental illness, because unless we reduce the stigma and discrimination nothing else is going to happen. And it is not just stigma and discrimination from the man and woman in the street; it is the men and women in parliaments here and in the states, because that is where decisions are made which are going to impact on their lives. That is my advocacy message for today, in that sense.

I want to expand a little bit on the research bulletin and its recommendations, as well as talk a bit about the bereavement work that we have been doing. From what you have been saying, you have been hearing quite a bit about bereavement work, but this is specific to our constituencies. Finally, I do want to talk a bit today about the Mindframe program and the media work that is happening, because there has been a lot happening in the media recently that I think it is worth commenting on and giving you a bit more information about what the Australian federal government is doing in that area and some of the research that is happening.

Firstly, turning to the research bulletin, the surveys that we do here are opportunistic surveys. Specifically, our focus is on people affected by mental illness. In this one, we were looking at people with a mental illness who have made a previous suicide attempt or have self-harmed—so, very high risk people. We know that having a mental illness puts you at a higher risk of suicide

and we know that people who have made a suicide attempt have a higher risk of suicide. So we had a very high risk group here and we really had some quite horrifying findings. We found that, even with this very high risk group, 80 per cent of them were not provided with a crisis plan following a suicide attempt—that is, they were not given information about what they could do in future when they felt suicidal. That is about guiding people through who they can contact, what their contact numbers are, who is a back-up person, what helpline they can call if someone is not available—and we did find that people who called helplines found them helpful. There is always someone you can contact. It is also about talking to someone about what helped them stay safe this time, to tailor it for that individual. So it does not have to be extensive; that sort of crisis plan could be on one card.

Likewise we found—and remember that these are people diagnosed with a mental illness; this is not a general community group—that almost 60 per cent were not referred for psychological treatment. Now, again, the evidence is very strong that that is effective. But we have a high-risk group not being referred for such treatment. There is something not happening. The communication is not happening. The links are not being made. It is certainly not a seamless service out there.

So there are recommendations that we make very clearly there. The first one is probably the most important, which is that the penny has to drop at some level that having a mental illness does put you at high risk of suicide. One of the things that I notice time and time again is: when you go to mental health conferences, they tend not to talk about suicide prevention; when you go to suicide activities, they tend not to talk about mental illness. This is stigma in action. So there has to be much more real understanding and internalising of the fact that having a mental illness does put you at high risk of suicide—that, for many people, it is a terminal condition. So that sort of thinking has to happen.

General practitioners, for example, do not always make that connection. Mental health services are trained to do suicide risk assessments, but then emergency departments do not always have mental health specialists there. So people can fall into those cracks. Something has to happen to make it much more of a seamless service. It is not for the want of people trying, but there needs to be more sustained effort, for longer, with more people for that to happen. That is all I will say about that particular bulletin, otherwise you will not have a chance to ask any questions.

I have got some resources for you all. I would strongly encourage you to look at this 20-minute DVD, just to reaffirm your belief that work in bereavement is important. Also it acknowledges that there are some additional concerns when someone is a family member or a friend of someone with mental illness who has died by suicide, because often it is not until the death by suicide that the family and friends come to terms with the mental illness. Plus, as we all know, mental illness can run in families, so when people are bereaved because someone with a mental illness has died by suicide, that may well make them extra vulnerable to relapse themselves. We know that being bereaved by suicide puts you at higher risk of suicide and, certainly, of mental health problems, especially if you are already in a slightly higher risk group. This DVD is not depressing. It is actually quite uplifting, and we have the most impressive people telling their stories here. It will reaffirm the importance of doing work in this area, as a suicide prevention strategy. It is not just doing nice things to support people after suicide; it is

actually a prevention strategy for these folks for themselves in the future—that is what I want to stress there.

These are guidelines that have been produced for mental health services, many of which, very rightly, have policies for supporting staff after suicide but have not developed guidelines for supporting their clients or the families of people who have died by suicide. So, again, it is just twisting that thinking a little bit and saying, 'Hey, there are things that we can do,' and, 'It's not an admission that you were at fault.' It is acknowledging that these folks are vulnerable and just giving a helpline number or a contact. Acknowledging that the suicide has happened is really very important.

There is some media material. There has been a lot in the media recently, some of which has been really good and some of which has been a bit more concerning. I am on the Australian Suicide Prevention Advisory Council, and at our last meeting it was commented on that the departmental report did not necessarily give you copies of the Mindframe material. So I have brought some of them along today so that you can see the guidelines. There is just one of the more complete documents, which is the resource that has come from the work that has been done for stage and screen with the Writers Guild. I have been involved with the Mindframe program for many years. I have to say that this is a very impressive, comprehensive, well-thought-through program. And I am not taking credit for that myself. I think it has been very well thought through.

There has been work done with a range of groups. Work has been done with reporters, who are writing news reports or feature stories for magazines, but also with the Writers Guild, with those who are preparing the scripts for television drama and soapies. As we know, many people do not watch the news, but they certainly do watch television programs and that is where their attitudes and information come from. There has also been some work done with the police and courts, because very often court reporters will pick up reports from the courts and run with them verbatim, not realising that they have responsibilities to perhaps be a bit more thoughtful about them.

There has also been work with the mental health sector because, believe it or not—and you probably will believe it because you have been around and you have heard from these services—sometimes the stigmatising comments come from the mental health experts who are being interviewed and not from the journalists who are writing the story. So Mindframe has been very careful to go to the source of information and attitudes rather than just the media themselves. The critical thing about the Mindframe strategy is that it is not just a group of mental health people out there wagging their fingers; there are media involved in developing the strategy and the media and mental health group comprises people from the Press Council, the ABC, SBS, commercial television, radio et cetera. It is very much a joint activity. That is the framework for Mindframe.

The other thing I have circulated for you is some recent research. It does say 'Draft, not for circulation' on the copies I have given you but it has since been distributed; it just so happened that I had these copies and I hate to waste paper, so I am giving you these. The research has been done by Jane Pirkis and Warwick Blood. They are both very highly respected researchers in the area, and the conclusions they have come up with support the continuation of the Mindframe initiative but say, 'Exercise some caution'. Their conclusions are to not censor, and no-one has

ever suggested censorship. That is a strong point: no-one has ever said, 'Do not report suicide.' The message all the way through has been, 'Think twice before you report on it and then be sensitive and responsible about how you do it.' On page 5 of their report, they say:

Presentations of suicide in news and information media can influence copycat acts in particular circumstances—

and there is enough research evidence now to show that.

So we have to keep with our message that media presentation should be done responsibly and balanced against the public's right to know. The public does need to know. It was fascinating listening to the previous witnesses' evidence on the reluctance of people to talk about suicide. I think there is a reluctance by people to talk about suicide in public but that it is talked about in private quite a lot. I think the sensitivity is there because families, as we know, are always very prepared to beat themselves up, to use that phrase, when anything goes wrong, families are feeling exceptionally guilty when suicide occurs and people are respectful of that and do not wish to add to the guilt. Something that I wrote down when the previous witnesses were talking is that we do not want to normalise suicide; we want to normalise the risk factors for suicide: the mental health problems and the mental illnesses that may result in suicide. That is where I would certainly exercise great caution. People say that we need a national suicide campaign, but that could run the risk of normalising suicide. What we do need, though, are national campaigns to destigmatise mental illness, to encourage people to get help early for mental illness. We know that one in two people will experience a mental illness in their lifetime. It is a normal part of life in that sense, and we have to encourage people to feel comfortable about asking for and getting help and make sure that the services are there to help them; that is the other big thing there.

This is a very user-friendly piece of paper to read. It is a recent news report from CNN about psychologists and the American Foundation for Suicide Prevention coming out and saying that public memorials 'can trigger more suicides'. That is just another word of caution. Yes, we have to talk about suicide as an important issue—far, far too many people are dying by suicide—but there is a balancing act that we have to be very careful about. If we talk about suicide too much, it can normalise it and make it an acceptable option, and nobody wants to do that. Again, we have to exercise caution, and that is where I think the Mindframe program is certainly playing a very important role. There is a lot of stuff happening under the bonnet with different groups to try and make sure that reporting and the issue of suicide is brought out but that it is done in a responsible way. I will stop there.

CHAIR—Thank you. Senator Moore.

Senator MOORE—Ms Hocking, your submission, as always, puts up a lot of challenges in terms of awareness and what should happen. You have been involved with our committee over many years and many different inquiries. What kinds of things do you think the committee should be looking at in terms of recommendations?

Ms Hocking—Certainly, that the government, whichever government, really has to continue with major, major policy, funding and programmatic support to ensure that suicide prevention activities happen. Now, suicide prevention activities in most instances will not be called 'suicide prevention activities'. The Men's Shed is not called 'a suicide prevention activity', yet it very plainly has that role; you are looking at the risk factors.

I cannot say often enough—and I am not doing my job properly if I do not say—that improving mental health services would be one of the most important strategies to reduce suicide rates. How that is organised federally or state wide is a juggling act that better brains than mine have to work on. But I think that the end result for people experiencing mental illness should be that they can get help as early as possible, as effectively as possible, for as long as needed and in the least restrictive environment, and there need to be a mass community campaigns to ensure that people know what the early signs are and when to get help and that they feel that it is okay to get help—so destigmatising it.

At the risk of going through everything I have already said today, there certainly needs to be a major thrust to ensure that there is a comprehensive long-term strategy to reduce suicide. That is about looking at at-risk groups, where there are targeted interventions, as well as community-wide strategies. The LIFE Framework is pretty good, actually, and it needs to be supported properly, decently, to be able to be implemented, not have half-hearted bits here and bits there. It is really important that it gets proper, long-term funding.

Senator MOORE—Sure. In terms of the focus, while it is stressed everywhere that not everyone who commits suicide has a mental illness, it seems from your submissions and your statements that, if we cannot get the mental health strategy right, there is little hope for the suicide prevention strategy.

Ms Hocking—I think, at the end of the day, we have got to grasp that nettle. I know it has been a difficult one because traditionally services have been run at the state level, so the Australian government has some reticence, I guess, about making strong comments in that way. But I think that we do have to make those strong comments; we definitely do. We know who these at-risk people are. We know where they are. We have got to do something.

Senator MOORE—Okay. Thank you.

Senator ADAMS—You heard me asking questions about rural areas to other witnesses, so my first question is: what work do you do in rural areas?

Ms Hocking—The main work we do there is our education work, that is, the production of guide books, pamphlets, CDs, a whole range of educational resources about mental illness, early signs, treatment, et cetera. We have a national free-call helpline, so anyone from anywhere around Australia can call us absolutely free of charge and get information, advice and referral. Our website, when people have access to websites, is obviously available. People can download information in print form or in podcasts and can send online inquiries to our helpline so, at that level, that would be our major service delivery, if you like. Certainly, research is conducted with people right around the country, in rural and remote areas as well, and our advocacy is very much for people in all parts of Australia.

Senator ADAMS—So it is with the use of the online hits on your website and also the online calls. Have you evaluated that: is it rising or is it going down?

Ms Hocking—Our website hits are increasing very, very dramatically. I would say our helpline calls have probably plateaued but the complexity of them has increased quite dramatically as people go to the website to get the information, then that may be enough for

them. They can get that anonymously very quickly and easily. Often people then call, having got the information, and say they have got a particular query, or we have people calling who have multiple issues and that is a matter of teasing out just what the priorities are and what their best call of action is. There certainly needs to be much more done for rural Australians, there is absolutely no doubt about that in terms of service delivery. I think that there is much more now available for people at that very early stage and the more that can be done at that stage, in knowing what the early signs are and that is acceptable to ask for help, then the less likely, hopefully, it will be that there are complex problems later on.

Senator ADAMS—And then there is Facebook. It was not a suicide, but the death of that young boy who was stabbed at school and the way that the world exploded around that with all the different messages must have absolutely devastated the family. Have you had any experience or any evaluation of the suicide of a young person perhaps and how their peers have reacted?

Ms Hocking—SANE Australia has not done that but the University of Melbourne has done some work looking at social media in that role. That was through Jane Pirkis's department; Andrew Dare has done some work on that. I could ask him to send some information, if you would like to see that.

Senator ADAMS—That would be good if you could.

Ms Hocking—Certainly, I think it is an area of real concern. It reflects a little bit of this 'In Memorials', because sometimes they can glamorise and give other vulnerable young people a sense of 'Ah, if I do that I might be recognised in that way' and that is something we have really got to try to manage quite carefully.

Senator ADAMS—Now there is Twitter as well. Communication is now so easy for a huge group of people and I wonder whether there is a copycat issue and, if there is, just how we deal with it.

Ms Hocking—Exactly. I think it is not that they are all right or all wrong. I think there are some very beneficial things about Facebook, Twitter, whatever—I have yet to discover them—but certainly, I think many young people do get a sense of togetherness et cetera, but we have got to try and watch that it does not become actively harmful.

Senator ADAMS—But it is so hard. It has escaped; how do you pull it back?

Ms Hocking—I have not got any answers there, I am afraid.

Senator ADAMS—It is just so easy to communicate with all those people and you just do not know. They give the address to their so-called friends but then there is another friend and another friend. Where does it all end up? You just wonder if it hits vulnerable youths.

Ms Hocking—Yes. I know the Australian Media and Communications Authority, ACMA, do a lot of education with young people about how to be cybersafe. I think we need many more of those sorts of activities so that young people know how to use that media in a safe way and how not to misuse it, I guess—or how not to get caught up in the side of it that may be disadvantageous. The worrying thing about that is that they used to do education for 12- and 13-

year-olds. They now do it for eight- and nine-year-olds and they are starting to do it for four- and five-year olds. So it certainly is an enormous issue—but it is beyond my scope, definitely. That is an area where there needs to be much more. That would be the population-wide, very early prevention stuff. You could look at that.

CHAIR—I know a six-year-old who knows his way around a computer better than his mother does.

Ms Hocking—Yes, definitely.

CHAIR—He can get online and do all that sort of stuff.

Ms Hocking—You have been talking with groups like Inspire and others who are well positioned to do some work with young people to guide them on the use of those social media at a time of death by suicide. I would like to make one other point. I have heard the word 'success' used this afternoon a couple of times. I would like to respectfully suggest that when any notes are being made from this inquiry the words 'success' and 'failure' are not used.

Senator ADAMS—The reason I said that they were successful was that I was thinking about the broad range of activities that that group does. It was not actually a success as in suicide. It was just the fact that they were out there doing that work.

Ms Hocking—No, I understand that. It was just that a previous person did talk about 'successful' suicide. It was more in that context. That is me doing my Mindframe work.

Senator ADAMS—Yes. I would agree with that.

CHAIR—Can I ask about the issues around not having a crisis plan or a care plan. We have had evidence of that a number of times, and it seems to vary in different states. I think Victoria said that everybody who leaves care is supposed to have a care plan, but we have certainly had evidence from a lot of other witnesses that people leave without a care plan, without a crisis plan, or leave with a totally inadequate care plan.

Ms Hocking—Yes. It may be that it is not a very helpful plan. A care plan would be different from a crisis plan. A care plan, I would hope, would be much broader. A crisis plan is just dot, dot, dot.

CHAIR—Surely a crisis plan is as a component of a care plan?

Ms Hocking—Definitely.

CHAIR—It seems to me that it is absolutely critical. The two key things that you raised from the report were making sure people get a crisis plan and a care plan and making sure that people are referred to psychological assessment. Where do we need to go with recommendations? Your recommendation was that we need to recognise the risk, but we need to do more than recognise the risk.

Ms Hocking—Sure.

CHAIR—We need to say, 'Right, here are the resources.'

Ms Hocking—Yes.

CHAIR—What are the other things we need to do?

Ms Hocking—We know that through Better Outcomes care plans are written. With the crisis plan, at SANE Australia we are going to be developing a template that we are going to trial, which could be circulated to emergency departments, GPs and mental health services to show that it does not have to be a complicated, tricky thing but that it is important to work it out with the client, the person involved. This template can be distributed very widely to make it easier for people to complete a crisis plan.

Everybody, certainly within mental health services, within emergency departments and within general practice, is overworked and underresourced. We have to do what we can to support people and I would not want anything I have said to be seen as blaming individuals. The vast majority of people are highly committed and working as hard and as well as they can with too few resources.

CHAIR—In other words, if you had a template when somebody was leaving the emergency room you would—

Ms Hocking—I would hope that that would be a prompter. Sometimes if you do not have a piece of paper it is not a prompter. So we are certainly going to be trialling that. We have just revised our *SANE Guide to Staying Alive*. We have updated it and added extra bits to it. That is a guide for people with mental illness who have suicide ideations, so because of their illness or the impact of their illness they have suicidal thoughts and actions. It is to help them stay safe and look at strategies that will minimise the impact of those things, but also to include the crisis plan in that guide so they have that ready for when they need it. Their families can have copies as well.

CHAIR—How do we ensure more people are referred for psychological assessment? I take it from your comments and the stats that we need to ensure that more people are referred.

Ms Hocking—Yes, and the interesting thing about the survey is the highest proportion of people who filled in the survey, 54 per cent, had depression. They are probably not hitting mental health services as such but are being treated in GP practices. It is GPs who are the gatekeepers to psychological treatments, so we have to keep raising awareness that it is an important and effective treatment. It can be the main form of treatment or it can be ancillary treatment to medication. We have to strongly encourage GPs to continue to refer to psychological treatments and ensure that the funding continues to be made available. Whether the psychologists are in private practice or on salary is another issue, but the principle is that we have to encourage and support GPs to refer people for that.

CHAIR—Thank you.

Senator ADAMS—We have had some discussion on antidepressants and the problem of one antidepressant being changed and the gap before the other one takes over. In Australia the two

are not used together as they are in other countries to prevent that gap being so wide and other problems. Could you comment on that? Are we overprescribing antidepressants, allowing people to remain on the same antidepressants for ages so they become completely reliant and then they are not strong enough so they have to go to something else?

Ms Hocking—I would not necessarily support the notion that we are overprescribing antidepressants; I think we are probably underprescribing other strategies. I am not a clinician so I would not deem to make a clinical comment on that. I know that many people feel that they are underprescribed and that there are many more people with depression who are not getting help who would possibly benefit from it. On the idea of the change over time, I think it is now increasingly recognised that when medication is being changed is a high-risk time. I think there needs to be much more education provided to people about their illness, about their treatment and about risky times. There also needs to be more education for the people's families and friendship networks so that everybody is much more aware that this is a high-risk time and other supports are put in place.

If the policy is not to prescribe both together, and certainly I cannot comment on that, then I think we have to make sure that other supports are in place to keep people safe at that high-risk time. Anecdotally, I know of quite a number of people who have taken their own life at that time. It is preventable. Not every suicide is preventable, but I think those ones in particular are.

I have one last comment to make, which is about the media work and the need for balance. I did not mention earlier that the other group we have to be very cognisant of at that time are people who have been bereaved by suicide, because every time they read something in the media there is a PTSD type response.

CHAIR—It reinforces it.

Ms Hocking—So we have to ensure that we balance up everybody's interests. Just having more and more written and reported is not necessarily the way to go. What we report, where, to whom and about what is the key thing.

Senator ADAMS—Probably an unfortunate example of that is the news reporter. It is just not going away. Those poor parents, her family and her boyfriend. Every time I see it I think, 'Are they ever going to be just left alone?'

Ms Hocking—Yes. I am very conscious of that. Certainly in Victoria this year a lot was written in the media, helping everyone understand at the anniversary of the bushfires that people would be having flashbacks about that. This is an everyday occurrence. For each family it will be different days of the year, so there is not that same mass recognition. But I think that, at a micro level, that is what is happening: every time a suicide is reported, there would be families right around the country reading it and reliving their experiences.

CHAIR—Thank you. I think we gave you some homework as well.

Ms Hocking—Did you?

CHAIR—I think there were a couple of things you said you would send us.

Ms Hocking—Right. I think there was the link to Andrew Dare and to send the social media report. Was there something else?

CHAIR—That is it. If there was anything else, we will send it to you to remind you.

Ms Hocking—That is fine. I am not sure whether my colloquialisms, my slangy words, will hit the full report; do they?

CHAIR—Yes.

Ms Hocking—The do; every single word?

CHAIR—Yes.

Ms Hocking—Okay. Including my final comments there.

Committee adjourned at 4.57 pm