COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Suicide in Australia

TUESDAY, 18 MAY 2010

CANBERRA

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SENATE COMMUNITY AFFAIRS

REFERENCES COMMITTEE

Tuesday, 18 May 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, 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 10.50 am

BODE, Mr Garth, First Assistant Statistician, Social Statistics Group, Australian Bureau of Statistics

SCHMIDER, Ms Anneke, Director, Social and Demographic Statistics Branch, Australian Bureau of Statistics

CHAIR (Senator Siewert)—Welcome. The committee is continuing its inquiry into suicide in Australia. This is our final hearing in Canberra. I understand you have been given information on parliamentary privilege and the protection of witnesses and evidence. As departmental officers you will not be asked to give opinions on matters of policy, although this does not preclude questions asking for explanations of policy or factual questions. If people try to push the line, we will jump on that, but you could be asked factual questions on when and how policies were adopted. The committee has your submission. Thank you very much for that. I invite you to make an opening statement and then we will ask you some questions.

Mr Bode—Thank you very much. The Australian Bureau of Statistics has for many years provided key statistics on suicide deaths. The collection of information on suicide deaths in Australia is inherently complex, comprising information from all the state and territory registrars, in addition to information from coroners, which is collected through the National Coroners Information System.

In its submission to the inquiry, ABS highlighted the main issues in relation to providing accurate statistics on suicide in Australia. These factors are: quality and completeness of the source data, timeliness of receipt of the source data, ABS processes for coding a death as suicide, and the framework and rules used for classifying a death as a suicide. These elements have been reflected in many other submissions, notably those of the National Coroners Information System and the National Committee for Standardised Reporting on Suicide. The ABS submission to the inquiry described improvements that ABS has undertaken with regard to suicide data. For example, ABS sought to ensure that users of suicide data were aware of the limitations in the data through improved explanatory material in our publications. ABS has also sought to work with stakeholders to improve data quality on a range of fronts, which are also detailed in the submission.

ABS has also implemented a revision process. I will just briefly describe that revision process, which has been put into effect for the first time in our recent release. For 2007 reference year data, we have applied revisions for the first time to the originally released data on suicides in 2009 and have included them in the 2008 publication which was released earlier this year. The revisions process allows for the fact that many suicide cases are not closed at the time of first publication of a given reference year by the ABS. The cases may have been closed in the subsequent period, allowing improved coding of cause of death. Using the revisions process, the number of suicide deaths for 2007 has been revised upwards from 1,881, which was the figure originally published in 2009, to 2,054, which we published in March 2010.

Our revisions process is now being applied for a second time to the 2007 data and will be published in March 2011, when we release our preliminary data for 2009. The ABS will then review the application of the revisions process to understand the impact of the two subsequent revisions to the original preliminary figures for 2007.

Since that submission, as I mentioned a minute ago, the ABS has released causes of death for 2008—in March this year—in which we presented a marked improvement in the quality of suicide data. Suicide data published for the 2008 reference year reflects process improvements within the ABS. There were a total of 2,191 deaths from suicide in the 2008 reference year in that publication. This suicide count was positively impacted by improvements made to the coding of coroner information we get from the NCIS, with all open and closed coronial cases coded according to ICD-10 business rules using all information available to the ABS. That means increased specificity of ICD-10 codes, in particular for open coronial cases, and a more robust count being available to users in the first instance for 2008—that is, the preliminary count. Of course, with the revisions process, 2008 data will be revised when we release data next year. Details of the process improvements for 2008 preliminary data and the process for revisions, which I have just described, are included in the technical notes for the 2008 publication.

The ABS is also currently considering what improvement process could be applied to data for years previous to 2007 to improve historical time series. As I just mentioned, we have introduced improvements for 2008 preliminary data and we have a revisions process which will apply for 2007 onwards. For prior to 2007, we currently just have the data we have previously published. The substantial nature of this task—going back to years before 2007—means that resourcing will have to be considered, especially in light of the significant resourcing required to continue to produce our improved quality data for current and future outputs.

As highlighted in the ABS submission and confirmed by other submissions and discussions at the Senate inquiry, areas for further work include ensuring that information is adequately captured and transferred to the NCIS in a timely manner and influencing the development of the ICD classification in order to make the classification of a death as suicide more accurate.

The ABS acknowledges the range of constructive comments made to the inquiry and welcomes any information or initiative which supports improved data on suicide deaths in Australia. The ABS is also active in many committees and groups seeking to address these issues.

Senator MOORE—My first question is about the process of the revision in stats which you undertook. There was a lot of public expectation that this was going to be announced on a certain date, and the date came and went. We on the committee were taken by surprise when the process did happen, because none of us knew about it. Can you tell us whether there was a media process for letting everybody know that the long-awaited statistical information had been announced?

Mr Bode—Are you referring to the delay in the release of our 2008 preliminary data?

Senator MOORE—Yes. There was a lot of community and industry expectation. The date came and went.

CHAIR—It was 17 March, I think.

Mr Bode—The decision to defer the release of that data was made on the grounds of concerns about quality and the extent to which we had explained some aspects of the quality of that data. One of the things you might have noticed—or you would not have seen it, actually, because you did not see what we had previously been going to publish—is that we went right through all the explanatory material, the technical notes, to try to make sure that we had explained, in a very clear way, the improvement process that we had implemented for the 2008 data and the particular aspects of the revisions process for 2007. It is unfortunate we had to defer the release, but it was purely on the grounds that we did not feel we were ready at that point to release the information and all the explanatory material that goes with it. When we made that decision, which was very late in the piece, we did announce it on our website. I think we did some other media announcements as well.

Ms Schmider—We had several media inquiries, and a lot of groups we are in normal contact with contacted us as well. So we were in contact with them during the delay period, which was two weeks, letting them know. There was a media release associated with the final publication. I think it was on 26 March. Also, prior to that, there was a release date put up on our website. So there were a number of personal contacts going on with people who had expressed an interest in knowing when we were releasing it, as well as public awareness on the website.

Senator MOORE—I have no problem with deferring a date when you are wanting to get ready. I was just concerned about the lateness of the decision, because people were hanging out for it. I have to admit I did not know the final publication. I take total responsibility for not being a regular on the Bureau of Statistics website. It is not something I go to all that often.

CHAIR—It was just before Easter.

Senator MOORE—It came as a bit of a surprise about something which had been awaited for so long. Certainly we tend to get standard releases in our office, but nothing came through to say that data had been released. We actually found out, I think, through the secretariat that it had occurred. Fine. I just think that it possibly would have been useful if this committee, which had been studiously following these issues, could have got a release to say: ‘It’s now out. If you have any questions please contact us.’ I just wanted to get that on record because at the time it was quite an issue.

Ms Schmider—I contacted Owen, but I think it was a little time after.

Senator MOORE—That was fine. In terms of the process, just checking that this has all gone through now. You have explained, Mr Bode, that it is hoped the revision process, at this stage, will be a standard—

Mr Bode—It will be a standard process, yes.

Senator MOORE—The way the financial years go, the reporting years, there will be plenty of data in the explanatory notes explaining, ‘This is what we have and this will subject to future work.’ Is that dependent, as you said later, on resources in the Bureau of Statistics?

Mr Bode—No. We committed to the revisions process and we committed to the improvement process for preliminary data. What I was referring to then when I mentioned the availability of resourcing was going back in time through previous years. We basically have not been able to yet put together a revisions plan for those years. I would like to think we can revise some of those earlier years to improve the length of the time series, and we will be looking at that in the near future. We need to assess. We have had changes in systems. We have to make sure we have available the data we need to do it. We have to be able to then get the resources to go back into 2006 data and then into 2005 data when we are also trying to process 2009 data and 2010 data. We will be putting together a revisions plan for data prior to 2007. At this stage I could not tell you when we would be putting our feet down on how far back we would be going.

Senator MOORE—How far you can go back and so on would be subject to a whole range of stuff, I would imagine.

Mr Bode—Yes.

Senator MOORE—I know you have followed the submissions. We have a submission from the Suicide Prevention Australia working group, of which you are a member. Has this new process gone back to be discussed with that group in terms of the group's expectations about what could happen with Bureau of Statistics data? We were going to hear from that group this morning, but because of illness we have not been able to, so I have not asked them what has been done subsequently. So since 26 March has there been a further meeting of that working group where you have been able to present this new process and look at the future?

Ms Schmider—There is a meeting coming up on 18 June with that particular committee. So we have not actually had an opportunity as yet to talk with that committee specifically about their thoughts about the 2008 publication and the 2007 revisions, but I fully expect that will be on the agenda and we will be there to discuss it then. We have been in contact with other key users of the publication to gauge their perspectives, but I think everyone is still digesting. There is a lot of newness in what we have done that will take a while to filter through in terms of what it means for analysis and for policy.

Senator MOORE—Can you tell us who the other key users are? When you read through who the members of that working group are, who—not members of that working group—would be considered key users of this data?

Ms Schmider—A number of them are on that committee anyway, but I have spoken separately with the Australian Institute of Health and Welfare—

Senator MOORE—They are on that group, are they?

Ms Schmider—They are on that group, yes.

Senator MOORE—I am trying to find out who, not on that group, are the other key users of this data.

Ms Schmider—There are a number of non-government organisations which the committee has also spoken to or will be speaking to—those like beyondblue, so those outside of government agencies. We have spoken with the Department of Health and Ageing, who also have, obviously, an interest in our data. They are the key ones I can think of at the moment that we have had, outside of people in that group. I have also had discussions with Professor James Harrison, who is a member of AMDIG, regarding our data and how it is used, and how he is finding it for his purposes.

Senator MOORE—Is it proposed to have any public seminars on this change?

Mr Bode—Not at this stage.

Ms Schmider—No, not at this stage, though more from the perspective that perhaps we have not thought about that particular aspect. But we could possibly do that.

Senator MOORE—It is just that there was widespread interest in the process.

Ms Schmider—There was, yes.

Senator MOORE—Perhaps we are talking to people who have a particular interest, but there have been hundreds of people who have been contacting this committee and I would think that interest would extend well beyond just the members of this group.

In the paper we have had from the working group, there were a number of other things they said which were subject to further consideration beyond the specific provision, and that is going to various groups. But certainly one of the core aspects was the quality of the data which was going through to the coroners' group, so that, if the coroners' officers have the responsibility for providing the data to the NCIS—I always laugh when I hear that!—

CHAIR—Yes, so do I—you expect a TV program!

Senator MOORE—They provide it to the NCIS. But, in terms of process, that is something that no-one has any control over. So, in terms of the ongoing work you are doing, are there concerns about the quality of the data on which you have to make your work operate?

Mr Bode—It could always be improved; there is no doubt about that. You are specifically referring, I think, to the speed with which individual coroners can process cases and complete the cases, but then also load the data up to the NCIS—there are two aspects to it.

CHAIR—It is the coding.

Senator MOORE—It is the coding; certainly, the basic stuff—that the police in particular are operating on different forms across the jurisdictions. Something as basic as the form that goes into the coroners' system is not standard.

Mr Bode—The lack of standardisation is definitely one area where we would think there would be room for improvement. Also, if coroners' officers could do that coding and get it onto the NCIS more quickly then it would certainly improve the end result for our codes.

Senator MOORE—And so the cleanliness of the data.

CHAIR—Can I just check: from the evidence we have received from at least two states—or one state and one territory—it is not just the quickness and the lack of standardisation; it is actually the quality of the coding. And in at least two states, we have been told, there is—and they are not having a go at the person—a very junior-level person entering the data and they have very little idea of any of the technicalities of the data. For example, we heard yesterday when we were in Darwin that somebody had actually missed a letter that was in the file which clearly showed intent. So the point was made to us that not enough resources are actually going into the coding to get somebody who is actually qualified in the area to code the data. So it is not just standardisation.

Mr Bode—You are talking there about coding which takes place in coroners' offices where they are coding it to the NCIS. We then do our own coding. Our coding process is totally separate from that and is done on top of that.

CHAIR—I am not having a go at your coding and I am not having a go at the people who do it. If you have somebody who does not have the appropriate qualifications and experience and is very junior, we have been told that they miss stuff. So the data you then get is—

Mr Bode—Suboptimal. If a more highly qualified clerk had done the coding in the case you gave, the end result would have been better data on NCIS and we would have had better data for determining our final cause-of-death code. Anneke, are you aware of any particular issues there?

Ms Schmider—I am aware of that general issue but not in a specific coroner's office. I would venture that it is a complex area and the more skills and experience people have in entering data into that system the better. From an ABS perspective, in our coding we are very aware of that as well. There is ongoing training and these coders need to make sure there is consistency and quality in the data.

CHAIR—So you have your own coding process. Do you actually train the coders from the states and territories as well?

Ms Schmider—No. There are coding courses that occur and we are involved in those, but ABS does not undertake that role.

Senator ADAMS—You obviously rely on the data which is fed to you, but do you go back at all and get access to the coroner's records or to where it is coded from before it goes to the coroner's office? Do you do that or do you just rely on what is given to you?

Mr Bode—Since about 2002 or 2003, we have no longer gone directly to coroners. For coronial cases, we rely on information on the NCIS.

Senator ADAMS—The information we have had is that some of the positions are fairly junior and it may not have been recorded properly in the first instance so, by the time it gets to the coroner, it is not as accurate as it could be. Then it goes to the NCIS and you are solely relying on data from them. Is there any way you can go back and check the next level to make sure that it is absolutely accurate?

Mr Bode—It is not an impossibility. As I said, since about 2003 our coding processes have been such that we go to the NCIS because it is a single source, it covers the whole of the country and it is a consistent source to get the data from. It makes it a much more efficient process. We could under some circumstances presumably go back to coroners, but the basis on which we did that would have to be built into our processes. I do not know what the trigger would be to go back to a coroner for further information other than what is on the NCIS. It would have to be a suspicion that there was inadequate information on the NCIS and there may be some more in-depth information in the coroner’s office which we could have access to. We do not do that now. It would be a very convoluted process if we had to graft onto our processes these additional activities of going back to coroners’ offices and making approaches to get information. I suspect we would not find a huge difference in the overall picture of our cause-of-death outputs if we were to introduce what is a fairly convoluted and time-consuming process by going back to coroners. That is my gut feeling, but I will hand over to Anneke.

Ms Schmider—In a data collection process, as dry as that sounds in this context, the effort would be better spent on the quality of the input from the coroners to the NCIS. It may also be duplicative and inefficient for ABS to then go back to the coroners. As Garth said, I am not sure on what basis we would make that decision and whether we would even know that there was incomplete information in the NCIS or how we would suspect that. From that perspective, I think the best effort would probably be at the quality level between the information in the coroner’s office and the NCIS.

Mr Bode—Which is the coding process we were talking about a minute ago.

Senator MOORE—Mr Bode, can I just get an idea of the time frame in your office in Brisbane about when this stuff is done?

Mr Bode—I will have to hand over to Anneke because she works in the Brisbane office and I work in Canberra.

Senator MOORE—I know it is the office in Brisbane that does this collection. What is the time frame for this particular return?

Ms Schmider—ABS publishes its preliminary rounds fifteen months after the completion of the reference year—so for 2008 it was at the end of March 2010.

Senator MOORE—Is that for the financial year or calendar year?

Ms Schmider—Calendar year.

Senator MOORE—So it is the calendar year of 2008—January to December. So 15 months after that you do the first round?

Ms Schmider—That is right.

Senator MOORE—The work on that would be done over what period?

Ms Schmider—Over that entire period. The ABS is receiving information on deaths from the registrars over that period.

Senator MOORE—Every week? I am fascinated about the process.

Ms Schmider—It is a constant process, yes.

Senator MOORE—Is it weekly or monthly?

Ms Schmider—Weekly.

Senator MOORE—So you go to the NCIS—

Ms Schmider—We receive monthly files from the registrars and we receive monthly files from the NCIS as well. It is a constant process.

Senator MOORE—The data is being input as it comes?

Ms Schmider—Yes.

Senator MOORE—And that is coming from the eight coroners’ offices?

Ms Schmider—Yes.

Mr Bode—It comes through the NCIS.

Ms Schmider—Yes. There are eight registry offices.

Senator MOORE—And then it is pulled together and the report is put out after 15 months. Under this new system, they are going to have the revisions done—

Ms Schmider—At the same time, over that same period. The revisions for 2007 were undertaken during that 2008 processing year.

Senator MOORE—It is a double workload.

Ms Schmider—It is.

Senator MOORE—That is a new workload. You were just doing the standard report up until now but, as a result of this change and the work you did over a period of time to look at how you could get it better, you are now going to do a double workload for a period.

Mr Bode—We will be doing that every year.

Ms Schmider—It is tripled because we have second revisions for 2007, the first revisions for the 2008 data due out in March next year and also the preliminary data for 2009. So there are in effect three processes going on at the moment—although the revisions are not as intensive as that first process because you are coding far more deaths.

Senator MOORE—Also the first revision you have done has now indicated to the staff what you have to do. So it was a particularly heavy workload while you were working out what the change was going to be, but now that has become standard practice to an extent.

Ms Schmider—To an extent, yes. From our system perspective, it is largely the manual nature of reviewing closed cases and open cases that is the intensive part of our processing.

Senator MOORE—And there would be no alternative to that. The only way you are going to get the information is to have someone reviewing it and using their skills to do that.

Ms Schmider—I think so. In terms of the quality of the final output, that is the way it needs to be—that is right.

Senator MOORE—Can we have a look at the wording you are going to put in? You talked about the extended information you are going to be putting out. Can we get a look at what that is going to say?

Ms Schmider—The time series?

Senator MOORE—No. You said you were going to put out extended information about what you are doing and how you are doing it.

Mr Bode—Explanatory information?

Senator MOORE—Explanatory information, yes.

Mr Bode—We did that in our 2008 publication that was released in March this year. We have several—

Senator MOORE—So it is going to be the same as that, is it?

Mr Bode—Similar to that. We will review it. That was the first time we had introduced both the quality improvements for the preliminary data for 2008 and the first revision for 2007. As Anneke said, we will have second revisions for 2007 next time, the first revisions for 2008 and preliminary data for 2009. We will have to change our explanatory material, but we will look for continuous improvement in that area.

Ms Schmider—Certainly with the release this year the technical notes that were added were, as Garth said earlier, designed because there is such a broad range of views on this information, ranging from academics to non-government organisations. These revisions are quite complex. The preliminary publications were designed to try to make very clear in laymen’s terms, as far as we could, what had actually happened.

CHAIR—Can I go to the issue of intent and the different ways that intent is recorded or not recorded across Australia. When we were in South Australia—I did not bring the particular quote up with me; I must apologise—we found that under the Coroners Act they do not have to record intent. Was that correct?

Senator MOORE—I cannot remember the evidence.

CHAIR—There is an issue around intent in South Australia, which is different to WA, which is different to the other states.

Senator MOORE—It is different in Queensland, yes.

CHAIR—It seems to me that it would be useful to have, dare I say it, a common, national approach. Is the definition and the way intent is recorded a continuing issue? Some jurisdictions seem to take a more precautionary approach to intent than others. Sorry, the South Australians do not make a finding—

Mr Bode—Yes.

CHAIR—unless they have an inquest. Sorry, it took me a couple of minutes to get there. Different states do it differently. Is that an issue for you?

Mr Bode—Eight different ways of doing it is a problem. The best out of those eight ways of doing it, or an even better way than that followed by all coroners, would obviously be a better way of doing it. I have no doubt about that. It would be better for our coding purposes, it would give more consistency for data across the states and territories and it would make the analysis and interpretation of the data much easier and certainly more reliable in terms of findings that people made. I have not seen any suggestion that that might be forthcoming. I suspect that there will continue to be eight different ways of doing it.

Ms Schmider—This exists for us across the collection as well: we have eight different registries with slight variations. Because it is administrative data you have to deal with the reality that there are slight differences in it as well. Sometimes they make it difficult to quantify what could have otherwise been.

CHAIR—I understand what you are getting at: all the data you have to code from the jurisdictions is not standardised across Australia. We are working on this particular issue. If we were to recommend, for example, that there be a standardised approach to the recording of coronial data and intent, would that be a bit silly to recommend outside of a process where we are saying the all data collection should be standardised? Do I correctly read that into what you are saying? Not that you would be saying that we would be silly to do that—I understand that—but that if you are going to look at data collection, there is no point just correcting one area; we should be correcting it across the board.

Ms Schmider—I actually think there would be great value in the one area you just described, absolutely, and particularly in relation to suicide data. That would make a difference to what ABS can process.

CHAIR—If we were to recommend that, for example, people wouldn’t go, ‘That’s silly, if you are not doing it for all data’? Our remit here is not about all data. This is a significant issue. It has come up across Australia.

Ms Schmider—Absolutely.

CHAIR—‘It is a significant issue, so at least you can fix that we are worrying about correcting all the other stuff.’

Mr Bode—The NCIS submission also drew attention to the fact that, I think, only four states and territories use the standard police reporting form. That is probably not the only area where there is lack of standardisation. That is information going into the coroner. You are not just talking about what the coroner actually reports in terms of intent; what feeds into that is, for example, a police report on what circumstances existed at the time of that death. That would lead to improvements as well.

CHAIR—Thank you. Can I go to the issue of Indigenous suicide. We have obviously taken quite a bit of evidence around that. We took quite a bit, obviously, yesterday while we were in Darwin. On top of all the other issues that you deal with, do you find specific issues around the recording of Indigenous suicides?

Mr Bode—Indigenous identification is one of the key issues because we are relying on an Indigenous identifier that is on the death record. Even if all Indigenous deaths are registered and complete information is available for those deaths, if we do not know whether or not the person is an Indigenous person then that will impact directly on statistics about Indigenous people, particularly suicide statistics. So the Indigenous identifier, the quality of it and the coverage of it are critically important.

Ms Schmider—Absolutely. There are three main aspects. There is the data that we receive and as far as possible, particularly from the registrars, we validate one Indigenous identification against another and the information in that registration, simply to make sure that we are getting adequate coverage of Indigenous identification. But both of those identifications are made by proxy people—for example, the funeral director on their form or the doctor on their form—and there are quality issues with whether it is completed and how accurately it is completed. All of those things will impact on how Indigenous deaths are then recorded in our causes of death system and, by definition, in the suicide data.

CHAIR—Has there been any work undertaken with the various jurisdictions to try to improve that identification process?

Ms Schmider—ABS have worked for quite a number of years with the registries on making sure that we have the two certificates and that we are able to validate and have a look at those things. We have recently been visiting the registrars, and a strong part of our discussions with them is understanding Indigenous identification and the issues that affect Indigenous identification in their data. It has been quite instructive.

Places like the Northern Territory are quite inspiring for the effort that they put into making sure their Indigenous identification and their birth and death records are very good.

Mr Bode—We have also worked with funeral directors in the past. I do not know whether we have been doing that recently, but I can recall that a number of years ago we were doing a substantial amount of work in that area because the material they provide is a big determinant of the Indigenous status of the person. We can always do more. If you undertake that work then you probably have to follow it up over time, because different people come into the workforce and the standardisation of the procedures that they apply can slide. We probably need to keep reinforcing the practices that need to be followed and the importance of the Indigenous identification, both on the medical certificate of cause of death and on the funeral director's information.

CHAIR—So is that an ongoing process for you?

Mr Bode—I would say it is. We can always do more, I suppose, but we are conscious of its importance and we work with the states and territories. We have other forums in the Australian Bureau of Statistics where we meet, probably two or three times a year, with state and territory government officials on statistical matters. Quite often the issue of Indigenous identification in administrative data, like births and deaths data but not only that data, becomes a subject for discussion. We are looking for ways in which the state and territory representatives that we deal with can influence other people in the state and territory systems and bureaucracies, whether it is in hospitals, in educational establishments, in their registries of births, deaths and marriages—in all those places we are attempting to ensure that they understand the importance of it and that rigorous processes are put in place and followed up.

Senator MOORE—In respect of the department, is it something that the industries with which you speak are interested in? When you are doing the follow-up with industries such as funeral directors and registry groups in hospitals, is it a popular process?

Mr Bode—That is a difficult one. It just means more work in some cases, I suppose.

Senator MOORE—That is what I was thinking.

Ms Schmider—The anecdotal evidence would indicate that in some circumstances it is quite difficult to actually ask that question—not only, as Garth said, in our deaths information but across a whole range of administrative datasets. People are reluctant, for whatever reason, to ask the question as to identification. It may be because it is a very sensitive and emotional time and there are perhaps cultural barriers as to asking that question formally of Indigenous families. There are other barriers that might make a funeral director or a doctor reluctant to actually ask that question. So at the point of collecting that information the context in which it is collected is quite important and can sometimes impede it.

Senator MOORE—So in normal processes you are filling in your own forms and you have a voluntary choice as to whether you tick a box or not?

Ms Schmider—That is right.

Senator MOORE—In this process with the funeral directors in particular, and it is an area in which I have not worked, can they actually tick the box without asking, if they are providing a service to an Aboriginal family? Is it a necessity that the question is asked and responded to or is it possible for a funeral director to tick that box? I do not know. I am just checking that through a question.

Mr Bode—They might know the information, but I do not know on what basis. I suppose in an ideal world they would be providing accurate information for that particular data item. In many cases unless they asked a question they would not be guaranteed accurate data. The procedures would probably be covering who they should seek that information from.

Ms Schmider—That is right. I think the best accuracy will be captured from asking the question formally of next of kin.

Mr Bode—That is basically the only way to know for certain. Even then, as you say, Indigenous identification is partly about the individual, whether they identify as an Indigenous person. So even then it is still a proxy piece of information from a next of kin person.

CHAIR—If I can follow that up while we are on funeral directors, we received some evidence—I think it was in South Australia—around funeral directors not necessarily ticking the box as to suicide. It raised the question of inaccuracy in the collection of data. Apparently they find it quite hard to ask the question, which I can understand. But is there not a formal requirement for those forms to be filled in accurately? Am I misunderstanding the situation there? If it is an issue, what is being done to address it to ensure accurate collection of information?

Mr Bode—Are you talking about the Indigenous identification issue?

CHAIR—Sorry, I am going back to the general issue. The talk about funeral directors reminded me of some of the evidence we received around their being reluctant to tick the form. Again, it is missing or not picking up some of the data. I think we were told about that in South Australia but honestly we have been all the way around Australia and I sometimes forget where we hear information. I just remember the information.

Senator MOORE—It was in South Australia.

CHAIR—Senator Moore thinks as well that it was in South Australia and I am pretty certain that it was. There was a comment made that funeral directors—and I can totally understand this—are reluctant to ask the family in an intense time of grief.

Mr Bode—I would not have thought funeral directors would be expected to provide information about the intent of the death if it were an externally caused death, but I could be wrong.

CHAIR—Sorry, did you say you wouldn’t?

Mr Bode—I would not expect funeral directors to do so. I do not have the form itself. I do not know which jurisdictions use which forms. But I would not have thought that a funeral director would be required to find out about the intent behind an external cause of death.

Ms Schmider—I am not aware of the particulars of the South Australian funeral directors form. If that is the case then I suppose the answer from our perspective is that such forms are collected according to each state’s and territory’s jurisdictional requirements. I am not aware of the particulars as to whether suicide is filled out on the South Australian funeral directors form. I would imagine that if it were there it would suffer from the same types of barriers to entering that Indigenous identifications do. It is about the sensitivities and the context around the collection that would be the barrier there.

CHAIR—Ms Bleeser thinks it may have just been relating to the Indigenous identification issue. I thought it was a bit broader than that. We will double check that.

Mr Bode—If that were the case, I would understand the issue because the form would be asking them to fill in the Indigenous status of the deceased person. Yes, they are supposed to fill that in, and fill that in as accurately as possible.

CHAIR—It seems to me that we are relying on that form regardless of whether it is the broader suicide issue or whether they are Indigenous or not. It is a form that we are relying on for information. As I said, I can understand that but how do we get around the reluctance of a funeral director to then fill out that form accurately? Sorry, I should take that back. It is not about their reluctance to fill that out accurately; it is about causing further grief to the family. I can understand that. But how do we then get accurate information if that is what we are relying on for our key piece of information?

Mr Bode—I think training and education processes are still the only effective way. You can institute all the standard forms and you can describe what a best practice process is for the funeral director to follow but I think nothing beats the actual systems of training and education that can be provided to help them realise and understand and then to actually take that extra step of collecting the data.

Ms Schmider—I think the other thing that may help as to this particular issue, whether it is Indigenous identification or the manner of death, is that there are electronic initiatives coming up around the registration process, so death registration is going to be completed electronically and some of these fields can become mandatory, which means that they must be filled out. There would be arguments about whether people would still then fill them out appropriately but at least with a mandatory field you know that some activity has taken place in somebody processing that record.

Senator MOORE—It would be mandatory when someone dies but it is not mandatory for anything else? On any Centrelink or taxation form and all those things they have optional boxes. It is an optional decision for someone to tick.

Mr Bode—That one could remain optional anyway because only certain fields would become—

Senator MOORE—Yes, it is one of those ones in terms of we want the information but it is in terms of what is a mandatory thing to fill out.

CHAIR—I would have thought, however, that the cause of death would have been—

Senator MOORE—From a medical perspective. I do not think it is a funeral director’s thing.

CHAIR—That is what I thought, that it was not a funeral director’s thing. We might look into that a bit further. As there are no further questions, I think we have reached the end. Thank you very much for your time and for the effort that you have put in to come here and also that you have put into your submission. That is much appreciated.

[11.39 am]

DE LEO, Professor Diego, Director, Australian Institute for Suicide Research and Prevention

HAWGOOD, Mrs Jacinta, Lecturer, Australian Institute for Suicide Research and Prevention

KOLVES, Dr Kairi, Senior Research Fellow, Australian Institute for Suicide Research and Prevention

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

Prof. De Leo—I am a professor of psychiatry and I have been in Australia since 1998. I have been President of the International Association for Suicide Prevention and the International Academy for Suicide Research. I am currently the director of the World Health Organisation Collaborating Centre for Research and Training in Suicide Prevention. Since late 2008 we have been appointed as the National Centre of Excellence in Suicide Prevention. I do not want to make a statement about the submission because I take no credit at all for the submission. I was overseas and the submission has been entirely done by my co-workers.

Dr Kolves—I have been working as a senior research fellow at the AISRAP for two years. However, before that, I worked on suicide research and prevention in Estonia for 10 years at the Estonian-Swedish Mental health and Sociology Institute. I have been involved in several European studies on suicide and on different international and WHO studies. I would like to mention very briefly the most important issues raised in the submission. The most important issue, as we have heard already, is the quality of suicide data and the underestimation of the number of suicides. Secondly, there are the gaps in treating suicidal people. Thirdly, there is the training of gatekeepers such as police and health professionals about suicide. As well, the education of new experts in suicide research is a very important field.

We have indicated that there is a need to include evaluation in the different projects and programs within the framework of the national strategy to create a strong evidence base, as there is in quite a few other countries in Europe. We have also proposed two different projects which specifically link to the issue of the gaps in the treatment of suicidal people. The first of them is the post-discharge care of psychiatric patients at high risk of suicide. The wider aim of this is to test how intensive case management works. There has been a pilot study. However, it needs to be tested on a larger scale. The second is a project called the Life House, which is an alternative to hospital care for acutely suicidal people without a major psychiatric diagnosis. Both of these ideas were created many years ago by Professor De Leo.

Mrs Hawgood—Thank you for the invitation to present to you today. I have been at AISRAP for just over 10 years. My former position, which I held for the first couple of years before I went into the lecturing position, was a senior researcher. I am also a clinical psychologist and I often work with suicidal young males. One of the primary components of my role at AISRAP is to coordinate, together with Professor De Leo, our postgraduate programs as well as the suicide prevention training workshops. In addition, I have been responsible for a number of research projects over the 10 years.

I would like to talk about the relevance of training and education, as well as the need for real-world research in the field of suicide prevention. This has been highlighted in our submission, so I may be a little bit repetitive in mentioning some of the things that Kairi has just talked about. My first point is regarding the tertiary based postgraduate suicide prevention education programs that we run. These are the first of their kind in the world. They are the graduate certificate in suicide prevention studies, the masters of suicidology and the masters with honours. In 2003 these programs were developed in the online capacity and since their inception in 2001 have attracted over 200 students, including both international and national students.

The programs aim to teach a 360 degree perspective of suicide and suicidal behaviour, so it is not just a medical model approach that is taken but one which also includes the social, cultural, biological, psychological and environmental perspectives. Students are taught to think critically and reflectively about suicide and suicide prevention. However, we believe that just over 200 is far too few students enrolled, and this has a lot to do with the lack of financial support available to assist potential students in the field to progress their knowledge at advanced levels. Our course provides both contemporary practice and research based elements.

On this note of financial constraints, AISRAP for many years has asked for government support in the form of full and half scholarships targeting high-needs students such as Indigenous students, low income earners et cetera, but to date this has not been forthcoming, despite the fact we have had three or four Indigenous students complete the program, which we are very proud of.

The second point is about education and training as a suicide prevention initiative. We know internationally that education of GPs is one of two demonstrated ways to prevent suicide, together with preventing access to means. Training usually takes the form of targeting, at a gatekeeper level, allied health professionals, community workers, including emergency workers, and/or targeting GPs. Since there is evidence about the effectiveness of this particular initiative, we often ask the question: why do we not invest more in this initiative?

On this issue, AISRAP developed with previous funding both online and face-to-face training and produced a book on this in 2002. Our evaluations have shown promising results, at least up to six months follow-up in terms of knowledge retention. Unfortunately, limited funding support again has resulted in the cessation of our online training program, despite the ongoing high demand for this training, with numerous inquiries from both government and non-government organisations.

Perhaps financial constraints have also halted the implementation of recommendations from the exploratory investigation AISRAP made into the need for a suicide prevention curriculum within Australian medical schools. We do not know why this important issue has not been followed up by the government, but the education of GPs and medical students is a critical issue, since many people who suicide and attempt suicide have consulted their GP prior to doing so.

Our study highlighted that there is a very great need and desire for suicide prevention curricula, especially skills based curricula, and this was based on data gathered from 10 out of 15 of Australia’s medical schools, GPs and undergraduate medical students. So, whilst we found 80 per cent of the medical schools in Australia did provide some type of suicide prevention education, our study also showed that the quality and the quantity of this was quite divergent. Irrespective, all study participants—from Australian medical schools, GPs and students—indicated strong support for a national, standardised or uniform suicide prevention curriculum.

So our study made recommendations to this end, including the estimated annual costs involved for the development, piloting and evaluation of such a curriculum. This was in 2008. However, we have had no response on the outcome of this report or an indication about the likelihood of a future suicide prevention curriculum for undergraduate medical students. We strongly believe that just one life saved would justify the money involved in the development and implementation of a national suicide prevention curriculum.

My final point concerns the proposal of two very important research projects, which Kairi mentioned before, that will fill important gaps in suicide prevention research and may lead to very critical positive outcomes for suicide and suicide prevention nationally and internationally. As indicated in our submission, these projects are treatment intensive and require the highest level of expertise in suicidology for both their operation and conduct. We have been really blessed with Professor De Leo with his leadership and expertise, and we really need to utilise that to try to run these projects, to inform policy at the national level. We would like to propose the replication on a national level of the post discharge care study in psychology—which Kairi mentioned—about patients at high risk of suicide, which has demonstrated very positive results, and a model of treatment for suicidal behaviour which offers an alternative to hospital based care for serious suicide attempters, and that is the life house. Both of these proposals represent real world applied research, which is rare in the field of suicide research and prevention.

In summary, as an international leader in suicide prevention education and training, AISRAP is well placed to guide and support the development of a national curriculum for Australian medical students. It is also committed to the continuation of suicide prevention training, but with funding we would be better placed to do that both online and more broadly with regress evaluation. Finally, the latter real-world proposals represent the first steps to assisting Australia to seriously research and seriously understand suicidal behaviour whilst filling a critical gap in the health system.

Senator MOORE—I study the funding that the government has given out on suicide strategies and I have become very close to this document. The listing has AISRAP mentioned twice: one is project 46 and the other is project 47. Project 46 is to provide advice. It is a significant grant to AISRAP for the period 2008-09 and 2010-11 to look at providing critical literature review and also general advice to government. Can you tell me how that works? What exactly are you supposed to do for that? You are the centre for suicide research in the country, according to the funding process. How does that operate?

Prof. De Leo—We have a research institute which, fortunately, is multidisciplinary. Kairi is a sociologist, I am a psychiatrist and Jacinta is a psychologist. We have economists and public health people. We also have a research clinic. We have a protocol that is verified and controlled for each patient, and I believe it is still the only one in Australia. Being researchers, we have the duty of being updated in the literature. We felt it was useful for the national suicide advisory board to be updated on the type of research that can be useful to the country, so twice a year we produce that type of publication. It seems simple but it is not, in the sense that there are no electronic systems today that can provide a complete view of the literature that is produced. We have to manage five different systems electronically. We have to concentrate, evaluate and read at least all the abstracts. Then the articles, which are potentially more interesting, are completely read, criticised and selected. Those that can be potentially useful for the government are produced twice in a year, and we give mentoring and instructions on what could eventually be useful for the government. This is the part of the work that we do for them.

We also respond continuously to requests about different topics. We are now dealing with a request on remote and rural suicide, and we are working on a problem which is a mathematical problem, because we rely on very good data in Queensland but we do not have the same quality of data for the rest of the country. The government wanted to know if we could extrapolate and imagine that the rest of the country is similar to Queensland. This is what we are trying to demonstrate mathematically with economic characteristics, et cetera. Before the last commitment was assessed, we have been working on the risk in Australia of specific groups of people having higher than the average risk of suicide. This type of work has normally been imported from overseas, so we did not have real data in Australia before, so I believe it is very useful, and the data is pretty different from what is reported in the international literature.

Senator MOORE—Do those requests come from the minister’s advisory board or from the minister? What is the link?

Prof. De Leo—It is what is called ASPAC, the advisory board, that makes these requests.

Senator MOORE—Is that subject to the same funding?

Prof. De Leo—Yes.

Senator MOORE—Any of these things that are summarised are very bland. There are a whole lot of dot points in this thing about what you are supposed to do, but that would come under, ‘provide advice on improving evaluation of suicide prevent work’ and ‘provide advice on the quality of suicide data’. So that would come under that huge remit that you do that work and feed it back.

Prof. De Leo—Yes.

Senator MOORE—Is the work that you produce then public or is it owned by the advisory group? The work you did on that project you just described, which was the risk of suicide to various groups in Australia—was that public data?

Dr Kolves—To my knowledge, it will be available on the internet. I do not think it is as yet, but it is fully in our submission as well.

Senator MOORE—So that is part of the research you do.

Dr Kolves—The second part is a particular project in 2007-08 and 2009-10 which was a WHO/START project. That is to do with different cultures and population subgroups within the Asia-Pacific—which is extraordinarily exciting, because it is actually within the region. How does that work?

Prof. De Leo—With difficulty, but it is working.

Senator MOORE—If we have data problems, I can imagine some of the problems in the Asia-Pacific!

Prof. De Leo—I have a long tradition of work with the WHO, starting in 1988, and I have been involved for 15 years in leading the European study on suicide, which was a historic study producing more than 250 scientific papers. It was a huge study. I met Dr Kolves within that study. She is Estonian. It was a magnificent exercise which ended in 2001. Simultaneously, WHO put me in charge of organising the SUPRE-MISS study, which means ‘suicide prevention intervention study’. This was a very rare, randomised controlled trial of a simple intervention for developing countries, showing how the monitoring of people and maintaining contact with people throughout 18 months makes an enormous difference in terms of mortality—not just non-fatal suicidal behaviour.

It is a historical exercise, a historical result. In any case, since the Pacific area made an inquiry to WHO regionally to be helped because of the rising rates of suicide, in 2008 we launched, still under my coordination and technical advice, the START study. It is called START also because, among the 37 nations and territories belonging to the Western Pacific area of WHO, nine of those countries do not have mortality data at all. So we are teaching them how to construct a useable standardised system for recording mortality that can be extrapolated by the user for malaria data or tobacco or cancer data, but we are starting with suicide. The study is running, among many difficulties. I would say it has 14 countries actively involved and, say, eight countries lazily involved in the study. So it is going on and it will help in growing an agenda for prevention of suicide in this particular area.

Senator MOORE—So the Australian government commitment would be relatively small. It says $300,000. I would have thought that was a drop. There would be other funding sources?

Prof. De Leo—WHO is providing funds and some other—

Senator MOORE—Possibly through our aid budget?

Prof. De Leo—No.

Senator MOORE—I will check that out. I am happy for Mrs Hawgood and Dr Kolves to answer this as well. Looking at the way our whole program operates within the country, we have had evidence from many places about the need for stronger coordination and for knowing what is happening in the field—that so much is happening but people do not know what each other are doing. The role of SPA has come up consistently, which is from the NGO perspective, and people who are interested get engaged. Certainly when you look at the research capacity that your institute offers, some of that would be knowing exactly what research is happening all over the country. I take it from the publication you put out that it is not just Australian research. You are responsible for looking at research internationally. Is that is right?

Prof. De Leo—It is right.

Senator MOORE—Having a one-stop shop so that if anyone is interested in suicide research—what is going on; what the newest aspects are—they would have confidence that there would be one place they could go to. My understanding of the way you have described it is that, since 2008, which is relatively recently, that is the intent of the Commonwealth funding to your institute. Is that right?

Prof. De Leo—You are pushing me to complain about why they funded me so late—yes, I agree.

Senator MOORE—I am pushing you to say whatever you think in terms of process and wanting to have an understanding of the best practice and the best knowledge in this field. My understanding of the research, from the way this reads, is that that was the government's proposal—that funding your organisation would actually provide that for Australian researchers. If they wanted to know what was going on, they would be able to turn to your organisation to know who is researching what in this country, and indeed across the world, on suicide. Would I be confident, if I came to your organisation or keyed it in, that you would know about anybody who is researching suicide aspects in this country?

Prof. De Leo—If I understood correctly and the question is, 'Do I know all the researchers in suicide in this country?' then my answer is definitely no. If the question is, 'Do I know the most relevant researchers in the country?' then yes, definitely.

Senator MOORE—Why would you not know, Professor? As a current researcher who is actively working in this field, why would you not know about them?

Prof. De Leo—Basically, I mean younger researchers or people who are entering the field of suicide independently. Clearly we should welcome these people, because one of the problems in this country is that there are only a very few researchers in this area. One of my dramas—I have no hesitation in telling you that this is contrary to Europe, where there are scores of people and you have a huge selection for a post of researcher in terms of the number of available candidates—is that to run the institute has always been very, very difficult. We cannot find people. We may have one applicant for a post of professor, whereas in Europe you can have 40 or 50. For a post for a younger researcher, a research fellow, we were very fortunate at the last selection to have had four candidates, but only one was doable, so to speak.

Senator MOORE—At least four people showed interest but only one met the requirement you had.

Prof. De Leo—Yes. It has always been very, very difficult. It is a very different situation in this country compared to Europe. Of course, there are other advantages and disadvantages, but it is a pity because the country is rich and beautiful, so there are many opportunities here. We see that there is potential but there is some work that needs to be done to explore this potential.

Senator MOORE—I will follow up on that later. With the work that you do in evaluating the papers, is that of all those who have published in the field? In relation to my question about anyone researching the field, you would not necessarily know all of them, but would you know all those who have published in the field? I do not mean personally, but you know what I mean.

Prof. De Leo—More or less, yes.

Senator MOORE—That is good, because I am—

Prof. De Leo—I have other complications and side effects in that I am the editor-in-chief of the main journal in the area, which is called *Crisis*—the journal of the International Association for Suicide Prevention—so I am obliged to read what people write around the world and make a selection. Even if I do not know them personally, I know them by name and what they do. So, in general, yes.

Senator MOORE—But they have published. I want to know who has published, if that would be a job you could do. Before I hand over, you have tweaked my interest by mentioning work situations and the issue of not having enough people who are working in the field. We are finding pockets of people doing lots of work. I think this is helpful. You mentioned in your evidence about your consideration of scholarships that perhaps one of the reasons that not more people are looking at doing postgraduate work in the areas that you are offering, and offering openly, is that it is difficult for people to afford to do that level of study. Would that be one of the reasons you would put forward as to why we do not have many people in Australia working in the field?

Mrs Hawgood—Yes, absolutely. Apart from a huge fear, I think, in workers in this field around competency in working with suicidal people—that is a very practical issue on the side—you find even with the Medicare scheme with their access sessions with bulk-billing and so forth that there are very, very few psychologists and allied health workers who will work with suicidal people compared to the general population of people with mental health problems and other problems requiring help.

Senator MOORE—Even within the area of mental health, suicide is a more difficult area?

Mrs Hawgood—Yes, it is much more difficult. Fear of litigation is an issue, despite how real it is in actual fact in terms of the need to prove negligence and all steps involved with that. It is fast becoming one of the biggest issues—this is feedback from my training participants and so forth—that prevent people from taking action. Research has shown that, even if people represent in a survey that they feel more confident after training and have a high intention to intervene with the skills learned or knowledge gained, it does not necessarily follow that with follow-up they actually go ahead and do intervene. So there are other obstacles. But that is just on the practical level.

One of the other aims behind our development of the postgraduate programs was to recruit from these programs not just more competent workers operating from an evidence base but also researchers to work at AISRAP. So there were two goals associated with that. If it were marketed that there was support there for workers to be mentored in a scientific way to complement their practice, I think we would have a lot more students applying for the program. The feedback that we have received from evaluations of our tertiary based programs has been so positive that I believe they can make a real impact at the grassroots level in that way.

Dr Kolves—I do not know, but my impression is that, as told already, the main lack is in suicide researchers, because there are several activities on the community level also involving the issues around suicide. For example, if I compare it to my country, we did not have that many different activities on the community level, but the research is also important, especially for the evidence base, to be sure and, as well, to know what the different organisations are doing. AISRAP at the moment is doing a mapping exercise to know what the different small organisations are doing, what is going on at the community level, so we can put them together to pose a stronger force as well.

Senator MOORE—It is critical—we have so many things happening—to try to find out where they all are. Professor, you wanted to add something on that?

Prof. De Leo—Yes, on both observations. What Kairi was saying is important because, particularly in this country, I have been proposing for many years this so-called mapping exercise. I remember starting in the year 2000 when I first was sitting on the national board, and we were given this assignment last year. Mapping means not only knowing what is in operation more or less actively in the country but also knowing which programs are overlapping or are duplication and especially what is expected from a program in terms of contacting people. We can have a beautiful program but it might touch only 200 people, so how can we expect outcomes in terms of suicidal numbers? We will not, so we need to make a photograph of what the recruitment area of the users of that given project could be and then make a credible sum of what we have been really affecting in our intervention and what we are missing out.

A simple way of overcoming this problem has been another frustrated attempt, which is comparing two populations on a large scale—for example, say, Tasmania, which has the right size for this type of exercise—and concentrating in Tasmania all suicide prevention activities for the government, for example, and using another of the states in which there is no such exposure. So you have a high-intensity exposure versus a normal exposure. You do not have ethical problems but you have over intensity in one population. If you were able to obtain results from this type of comparison, even if you were not able to disentangle clearly which one of the components was more successful than the other, it would not matter; at least you would have scientific proof that the overexposed area responded positively. But we could not do that so far, and we desperately need to. Many other nations are doing that, and of course we have the money, the credentials and the possibility for doing it, and I believe it is time that we do it.

With regard to what Jacinta was saying, there is an additional difficulty in finding suicide researchers. Suicide is possibly the most challenging area that exists in terms of scholarly studies because it is everything; it is not just medicine, psychology and sociology, it is also philosophy, anthropology and ethnology et cetera. To become a decent researcher you cannot just remain an epidemiologist because you will write just three or four papers in your life and then it is over. Or you can continue to be deadly boring in making epidemiology here and there in exotic locations, but that is it.

To grow as a researcher you need to amplify it to a larger perspective. This is where people find it difficult and limiting. From one side it is extremely charming—otherwise I should already be dead! I have been in this area for 33 years and the more I study the less I know, but this is the way it should be because it is really extremely difficult. It is like oncology in a way; we are not being successful with cancer—cancer is rising. But does it stop me from being interested in cancer? No—it is very challenging and fascinating. But oncology is much simpler than suicide knowledge, so we are expecting great results from suicidology and we accept that oncology is not providing results. It should be to the contrary.

Senator MOORE—How do your professional comrades who work in oncology handle your argument about suicidology being much more complex and demanding?

Prof. De Leo—We can have viruses, we can have antigens from the environment and we can have many factors causing cancer, for example. But we have many more factors causing suicide.

Senator MOORE—There is an argument there. I have taken too much time—we could go on for days—I do apologise, Senator Adams.

Senator ADAMS—That is all right—I forgive you! I would just like to come back to the training. I wonder what training is given to some of our first line emergency people like paramedics and, perhaps, fire officers—the sort of people who are usually the ones who are first on the scene or who are very involved? What are suicide rates among those groups? I have heard recently that in Sydney there have been some suicides within the top paramedics. That is really pretty tragic and I wonder what support and training they are given?

Mrs Hawgood—From 2000 to 2004, we received a lot more paramedics, fire and police attending our training. At that point, the field was becoming a bit more saturated with offerings of training from a whole heap of organisations. Just from our particular organisation, we probably—off the top of my head—would have had about 10 to 15 only attending community based workshops. It was a cross-sector of workers. In terms of specifically targeting those organisations, we provide tailored workshops when organisations like that approach us. We have done that on a number of occasions, but mostly we have presented in services about suicide at their own annual conferences—not a full on workshop per se. We have had two police officers complete our postgraduate programs and we have had about three or four ambulance officers. I cannot speak for fire fighters, but we have done two workshops just for the fire service at their annual peer support officer conferences. That is a general overview of what we have done.

We are available to organisations to do specific tailored workshops for them. But, sadly, in the literature I have not seen many suicide prevention studies on training and the impact on these personnel, since my review in 2006-07. I agree absolutely with the importance of training front-line professionals. With funding we are able to provide training for them. We believe wholeheartedly in it.

Senator ADAMS—But you have not actually done any research into whether there are a number of suicides in those areas?

Mrs Hawgood—We have looked into both ambulance and fire. The numbers are very, very small. We based our study on the Queensland Suicide Register, the QSR. We have also conducted a study on police, a confidential study, in one particular state. Apart from that, we have not looked at anything because of the small numbers. In our recent occupation paper that Diego and I were involved in there were not enough numbers to categorise emergency workers as an occupation of interest for the study, just because of the very small numbers.

Dr Kolves—But several other occupations are represented there.

Mrs Hawgood—We had nurses. Obviously there are a lot more nurses. There are farmers and industry and transportation workers.

Dr Kolves—Transportation workers, builders and agricultural workers had higher risks compared to the average.

Mrs Hawgood—The specific investigation that we did for ambulance workers a few years ago did not demonstrate any significant increase in suicide rates compared to the general population. We used NCIS data.

Senator MOORE—Where people from those industries have done your course, do you know whether they have had any industry support for doing it?

Mrs Hawgood—No. They self-nominated.

Senator MOORE—So the police and ambulance service did not help them to complete the training.

Mrs Hawgood—I could not speak for all of them.

Senator MOORE—But to the best of your knowledge?

Mrs Hawgood—To the best of my knowledge, quite a few of them did it for their own personal and professional needs.

Senator MOORE—Did they fund it themselves?

Mrs Hawgood—Yes.

Senator MOORE—If the industry provides funding for their workers to do it, that is another means of getting information.

Mrs Hawgood—They were given a day off for study and so forth. I also should mention that we have had a significant number of corrective services people as well. We have had quite a number of prison officers.

Senator ADAMS—I want to talk about the cost of suicide. Have you done much work on that? Have you looked at the cost of suicide to the community—looking at all the different aspects of a completed suicide and the consequences?

Dr Kolves—On the personal cost of suicides, we just applied for an ARC grant for a study on suicide bereavement. We hope to get that grant. It is a specific study design. It is a case-control study. We would like to compare relatives of suicide cases, after suicide, with relatives of people who have died from external causes of death. The study design is longitudinal, so it should last at least two years after the tragic event. The main aim is to figure out if bereavement after suicide is remarkably different or not.

There are not many studies on this topic. There are quite a few studies from Europe and from the US, but this is quite unique in Australia, and although there are organisations such as StandBy, who are dealing with suicide bereavement, this is a more scientific approach to that issue. Within the framework of another project called child suicides there is an important component about parents and especially about how parents are going through the suicide of a child: what are the consequences and how complicated is the grief? On the subject of social costs and more financial costs, at the moment in our team there is Dr Darrel Doessel, who is an economist, and we are starting to look more at those issues as well.

Senator ADAMS—You are starting to look at how the public authorities measure the cost of it, and that is really what we are looking at. So that study is starting?

Dr Kolves—Yes.

Prof. De Leo—We met last week approving a project that will evaluate direct, indirect and intangible costs such as psychic suffering, loss of pleasure in life et cetera. I hope that it could be of relevance to the nation to have this overview of what suicide may involve in financial terms, which is a necessary but somewhat cynical approach.

Senator ADAMS—It may be, but I think it is very important as far as funding goes, because if you cannot come up with these sorts of results from your research, then we need that funding to keep going and be able to make a difference. That was really the reason for my asking that question.

Prof. De Leo—I completely agree.

CHAIR—In the comments that you made about the life houses, you talked about them in terms of their being an alternative to hospital care. We have heard a substantial amount of evidence around step-up step-down facilities. Are Life Houses part of that process or something that you see as different? The step-up step-down process, as I understand it, is to help people as they come out of hospital care or for subacute care. Are the life houses the same sort of support services or are they different again?

Mrs Hawgood—Firstly, I have to be honest and say that I am not aware of the step-up step-down project.

CHAIR—It is through mental health.

Prof. De Leo—Is it that voluntary service that exists, for example, in Tasmania a little bit?

CHAIR—There are a couple already established in Victoria and Western Australia. They are investing some more; I think their aim is to have six in Victoria, for example. So there are some already established, but there are proposals to establish more.

Prof. De Leo—We need to move in that direction. We have tried in Queensland for several years now with no success, but this is a necessary move, especially because we are becoming responsible for medicalising a number of attempters and, what is worse, psychiatrising a number of these persons, putting them in a loop that is anything but positive. This model of intervention does not yet have a scientific basis because we do not have good controlled studies to show that it is useful apart from the Maytree study in the UK. That has witnessed some improvements, although rather than showing the crude rates the study has a very sentimental approach. But this is certainly a due evolution in the care of these people, because otherwise we will continue to lock all of them in for medico-legal reasons, which are increasingly important—if I do not want to be sued, I lock you in—and not discriminate between what is due to sadness or disappointment on the one hand and depression on the other. We should medicalise depression, but we should not medicalise sadness. We need a different helper for that.

CHAIR—Mrs Hawgood, were you going to add to that?

Mrs Hawgood—I was just going to endorse what Diego is saying about the approach of the Life House, how it is different. It takes a multidisciplinary approach and the model is based on the use of volunteers under the mentorship and supervision and guidance of more professional experts in this field. It is also encouraging the development of up-and-coming practitioners in a supported model with expertise guiding this specific area of such a complex phenomena, and to treat it requires that comprehensive support. And so the model, again as Diego was saying, involves their reintegration into community, but their rehab, from a social and environmental perspective, is where they do not require a medical intervention.

Prof. De Leo—One of the key issues is that when a suicide attempter—we have probably 100,000 of them in the country, but even keeping it lower than this number, 65,000 or 70,000 or whatever, is enormous. If I mingle with people like me, I can hope to be understood. But if I am with other people—a psychotic guy, a bipolar or a panic attack and severely disordered et cetera—I will be the most stigmatised of the patients because I am the one that has provoked an injury or a condition and did not have a diagnosis before, or in handful of cases maybe. Also our standards are very limited in providing knowledge of what happens at the community level. We know data for people who are referred to hospitals, so clearly the probability that a diagnosis is present increases if you are referred to a hospital, but the majority of people do not go to hospital. We performed a study of 13,000 in Queensland and published in 2005—honestly, a wonderful study; very costly, but wonderful and very quoted—and two-thirds of people who self-injure do not go to hospital at all. So all of the data that we have in the country is based on so-called separations from hospitals, and these provide a biased type of information because this is an extreme way of remedicalising people because we consider only the medical cases. They receive medical attention, so as a consequence they are medicalised. But the vast majority of people never enter into contact with that.

CHAIR—I think the concept is slightly different to the step up and step down houses, as I understand them, although I probably have a limited view in terms of what the vision is ultimately for step up, step down. But with Life Houses, the idea is not necessarily that it is for those who have a specifically diagnosed mental illness; it is for those who are contemplating or have attempted suicide or have actually self-harmed. It is a complete alternative to hospitalised care, whereas step up and step down facilities, certainly the way I heard it, is that they are not necessarily limited to people with a diagnosed mental illness, but are also available for people who have, for example, attempted self-harm, have been into the ED, for example, and are post separation, or for people who are diagnosed with mental illness and it is an alternative to hospitalisation for them. That is my understanding. So there are slightly different—

Senator MOORE—There is a hospital in the link.

CHAIR—Yes, there is a hospital in the link, whereas in Life Houses there is not necessarily a hospital in the link.

Mrs Hawgood—That is right.

CHAIR—But people who have been in hospital, I presume they can also access a Life House.

Mrs Hawgood—Absolutely, and the emphasis particularly being on either referrals from the community—GPs and so forth—or hopefully involving the holistic approach of the parents and/or significant others involved in the care as well to make the referrals. And also people who present at accident and emergency departments, who do not necessarily fit the in-patient status because they do not have a mental diagnosis. So filling that gap, providing the care and rehab for short-term—a couple of months intensive rehab for them.

Senator MOORE—Does this model exist overseas? So is it a working model elsewhere, we just do not use it in Australia yet?

Prof. De Leo—The first application was in 2005 and it was unsuccessful, but there is a model that I helped to inspire through the same concept. But the wife of Andrew Lloyd Webber, the famous musician, has created an association called Maytree in London. Her husband does not love her any more, but has left to her a lot of money, and she has invested a lot of money in this Maytree, which had a number of consultants and they consulted me on this model and I gave the basic ideas to this Maytree. They keep clients for a very short period of time, which is embedded to the concept of crisis, which is good. If there is a crisis, it needs to evaporate, but then there is also a phase of planning and entrenching or having a relationship with similar people. So what we propose is longer than that—a maximum of two weeks, otherwise it becomes an extended family. But for the time being, at a cost which is not hospital cost, but hotel cost—a very low cost, possibly less than $80 or $90 per day—you can render a service that then impinges on the total budget of a hospital indirectly.

Senator MOORE—So it is like a community health model?

Prof. De Leo—Yes, absolutely.

Senator MOORE—And you wrote this up and applied in 2005 and were unsuccessful.

Prof. De Leo—Yes.

Senator MOORE—That is what happens. But you have not given up; you have reapplied for funding?

Prof. De Leo—Yes, I swear, but we did not succeed.

Senator MOORE—Try, try and try again, Professor.

CHAIR—I want to go back to the issue of negligence, because it really has not come up that much before.

Prof. De Leo—The negligence?

CHAIR—The issue of people of being liable.

Prof. De Leo—In what way?

CHAIR—The issue around litigation. Mrs Hawgood, you brought it up, so do you want to go into that in more detail because it has not come up that much during the inquiry.

Mrs Hawgood—From experience with training and educating workers in the field, this is one of the biggest issues that we talk about when we educate about the impact on the worker specifically. So it is not just about the suicidal person. And in those units, the focus is on assisting people to develop an ability to reflect on the process between themselves and the client. And so in that process it is necessary to confront your fears and attitudes and a whole heap of things about the work that you do with suicidal people. One of the issues that come up is a fear of negligence, and so it creates distance even if it is unconscious, so we try to teach about becoming conscious and aware of the processes. While it is not a clinical focus—we will have people in the course who are not necessarily workers—it is still an important and even theoretical issue, particularly in the States, and we appear to follow the States in most behavioural responses. And in suicide litigation is such a big issue. Here, based on anecdotal evidence, even when workers are trained to competent, they still find themselves in a position of not feeling sure, feeling anxious, having fear and so forth. So you have a lot of referrals; before even seeing a client, referring them on because of the suicidality. I am sure there are a huge number of workers who continue to work, and we all do not know what we do not know, so we do. It is definitely an issue that comes up a lot in the work, yes.

CHAIR—Has much evidence of those issues been found in Australia? You are training people to be conscious of it.

Mrs Hawgood—Yes.

CHAIR—Have there been any examples in Australia where people have taken action against workers for negligence in handling a suicide situation?

Mrs Hawgood—Diego can probably better answer that question in terms of the numbers involved. I think it is very small but I am not familiar with the latest Australian data on the issue.

Prof. De Leo—There is ongoing research on negligence headed by an American called Lanny Berman. He is asking for material from friends in other countries, including me. This is clearly an issue, particularly in Anglo-Saxon countries. I believe it is too premature to give a quantitative dimension to this phenomenon. Clearly, the problem is very serious but the dimension is unknown, and I believe that interest in this topic is still in its infancy. We are starting to go around it. Should you be interested, I can put you in contact with my colleague in America, who is now President of the International Association for Suicide Prevention in Washington. He has been collecting data from at least 20 countries for the last six or seven months.

CHAIR—If you could provide the contact to the secretary, it would be much appreciated.

Prof. De Leo—Sure.

CHAIR—One issue that we have not really touched on today is suicide in Aboriginal communities. We have had quite a bit of evidence on this issue, including from our hearing in Darwin yesterday. From the information that we have received in submissions and from the evidence yesterday, I certainly take it that there are different issues around suicide in Aboriginal communities. In Aboriginal communities, an even stronger proportion of men than women suicide. Not as many women self-harm in Aboriginal communities as they do in non-Aboriginal communities. Have you done much research in the area of suicide in Aboriginal communities?

Prof. De Leo—We have a report but it has not yet been finally approved by the Queensland government. It is the strongest document ever produced in the country because it is based on 440 cases of suicide. There are no studies of this dimension in Australia. It was done in a rigorous way, so it is science; it is not politics. It gives a lot of information and also a lot of different information from what we possessed before, which can be particularly useful. I hope that I am entitled to tell you about this. I believe that you are the government, so ask me whatever you like and I will answer.

Senator MOORE—We are not really the government.

Prof. De Leo—This study not only permitted the establishment of the main epidemiological dimension but also added very clear views, given the numbers involved of all races, different age groups and genders. It also more clearly identifies what the circumstances were surrounding death and also the concomitant diseases, conditions and role of mental health in this type of suicide, which is strikingly different from what happens in the Caucasian community, apart from major psychiatric conditions. For example, schizophrenia and other psychoses are equally distributed.

When it comes to depression, for example, it is irrelevant in Indigenous suicide. Knowing that depression is measured with Western eyes, we need a filter or a better way of understanding what it is to be depressed, sad, melancholic, disappointed or angry. These are conditions that you cannot treat with an antidepressant. You have to treat them with human time and availability, which is much more precious than antidepressants and is more difficult to give. Apparently this is required but the ways in which these should be administered are still unclear.

One issue is that we do not have enough Indigenous researchers or mediators that can connect or meet with researchers in Indigenous communities. One of the biggest difficulties in starting this area has been that it is difficult to perform research because we are white and we are not very accepted. They probably have a very good reason. Still, the level of collaboration needs to be not only intense but very intense to provide this level of explanation; otherwise, they remain the opinion of a few scientists and not a reality.

CHAIR—You have given the report to the Queensland government. So it is just on Queensland or—

Prof. De Leo—Yes, it is a report. It will come out as a volume. If you do not mind I brought with me some material that can be eventually useful, and also some elaboration of the data that was the reason to trigger this inquiry—because unfortunately we are the first to raise the issue of data quality in the country. If you want it I would be happy to leave it with you.

CHAIR—Yes, the other reports would be useful. I just want to go back to the report to the Queensland government. When do you think that is going to be released?

Prof. De Leo—November 2009.

CHAIR—It has been released?

Prof. De Leo—That was the agreed date.

CHAIR—Okay. In other words: watch this space.

Prof. De Leo—We were ready by that date and we had a number of forewords, but none went well. So we have to now wait for an Indigenous person from Queensland to provide a foreword. We asked Adele Cox, who is on the ASPAC board, and I thought it was very representative. We also have a foreword to this report from Michael Barnes, who is the state coroner. But now we need another foreword and further control of the content before we can have this report out. I am looking forward to it because it can make some difference in the environment.

Senator MOORE—Which part of the Queensland government asked you for that report? Was it from Health? So Paul Lucas’ department asked you for that?

Prof. De Leo—Yes, mental health.

CHAIR—We will ask the government how far away it is. It sounds like it would be quite a useful report for us. Thank you very much. We very much appreciate your submission, the materials that you are tabling and the time you have taken to come down and talk to us.

Proceedings suspended from 12.49 pm to 1.47 pm

CARMODY, Mr Shane Patrick, Deputy President, Repatriation Commission, Department of Veterans' Affairs

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

HART, Ms Virginia, Assistant Secretary, Mental Health Reform Branch, Department of Health and Ageing

HUXTABLE, Ms Rosemary, Deputy Secretary, Department of Health and Ageing

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

PENNIALL, Mr Wayne, National Manager, Veterans and Veterans Families Counselling Service, Department of Veterans' Affairs

SAASTAMOINEN, Ms Tarja, Assistant Secretary, Family Health and Wellbeing Branch, Department of Health and Ageing

SINGER, Dr Andrew Harris, Acting Chief Medical Officer, Department of Health and Ageing

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

CHAIR—Welcome and thank you for coming. I know you are all experienced but I have to ask whether you have been given information about parliamentary privilege and the protection of witnesses and evidence. As departmental officers you will not be asked to give opinions on matters of policy, although this does not preclude questions asking for explanations of policy or factual questions about when and how policies were adopted. We have your submission; thank you. I will not ask you to give an opening statement until we are quorate because then you will be covered by the usual provisions. Do you want to give one opening statement or do you have one from each department?

Ms Huxtable—We have several that we have prepared if that is all right with the committee.

CHAIR—It is absolutely fine, yes. We have plenty of time, so that is fine.

Ms Huxtable—I might start if that is all right. The Department of Health and Ageing welcomes this further opportunity to present evidence to this committee and has a longstanding commitment to implement Australian government policy and programs that aim to prevent suicide in Australia. Since the department last appeared, there has been progress in a number of health areas that directly or indirectly support suicide prevention efforts. The Australian government has agreed with all states and territories except Western Australia, where negotiations are continuing, to establish a National Health and Hospitals Network to put the health system on a more sustainable footing and make structural changes to the way health services are delivered. The new health system's architecture will establish local hospital networks and local primary healthcare organisations—Medicare Locals—as well as putting in place new financing arrangements that aim to get incentives and funding flows working in the best interests of patients. These include the Commonwealth taking full funding and policy responsibility for aged care and primary care. Access to information at the local level, guided by strong national standards and information on evidence based best practice, will improve the responsiveness and transparency of services. The focus of health reform is to get the foundations and funding flows right to enable the health system to meet future challenges. As well, a number of specific budget measures address key pressure points: emergency departments, elective surgery, provision of subacute services, after-hours care and addressing obstacles to multidisciplinary care.

Improving the provision of health services for vulnerable people is central to these reforms. We all know that mental illness remains the largest single risk factor for suicide, and improving services for people with mental health needs remains a significant challenge. This was recognised in the COAG communique, where COAG asked that further work be done across governments on the potential for further reforms to governments' roles and responsibilities for mental health for report back to COAG in 2011. In this context, the Australian government indicated its intention to take a stronger policy and funding leadership role over time to improve services and outcomes for people with severe mental illness. As well, under the National Health and Hospitals Network Agreement, the Australian government will take full funding and policy responsibility from 1 July 2011 for primary mental healthcare services for common mild to moderate disorders such as anxiety and depression, including those services currently run by the states.

In the recent budget, the government confirmed a $175.8 million mental health package, including $123 million in new funding to fill some of the immediate gaps in the system, particularly to support more youth-friendly mental health services. As the committee is aware, one in four young Australians aged from 16 to 24 years will experience a mental illness in any one year, and most people who develop a mental illness will have done so by the time they reach 21 years. Despite this, they are the least likely age group to seek assistance. Included in the mental health package is a $79 million commitment to deliver up to 30 new youth-friendly mental health services and provide extra funding for the existing 30 headspace sites. This adds to the existing $51 million commitment to headspace. Funding of $25.5 million from 2010-11 has been provided to expand the Early Psychosis Prevention and Intervention Centre model, building on the successful implementation of this model in Victoria. With contributions from states and territories, this will mean that up to 3,500 young people will benefit from holistic care and support.

The sum of $58.5 million will be directed to coordinated care packages, providing both clinical and non-clinical care to better support people with severe mental illness who are currently being looked after in a primary care setting. These packages will be delivered through the Access to Allied Psychological Services, or ATAPS, program.

The government’s $1.62 billion investment in subacute care will bring additional step-up step-down subacute services for people with mental health needs, easing their transition from acute care to the community. These programs will provide better support to groups known to be at risk of suicide, young people with untreated mental illness and complex needs, people with severe illness, people with emerging psychosis and people post discharge who will benefit from step-down care.

Medicare locals being established through the network will better integrate and plan primary health care to meet the needs of local communities. They will also help to coordinate existing Commonwealth mental health programs, such as personal helpers and mentor services, support for day-to-day living and mental health respite.

As outlined in the departmental submission to this inquiry, there are four streams of activity under the National Suicide Prevention Strategy: the LIFE Framework, a strategic framework for suicide prevention, which has now been adopted by all jurisdictions as the basis of their suicide prevention activity; the Action Framework, which is a time-limited work plan for the Commonwealth against the LIFE Framework; the National Suicide Prevention Program; and alignment of Commonwealth and state suicide prevention activities under the Fourth National Mental Health Plan.

The National Suicide Prevention Strategy is national as it guides and involves state and territory as well as Commonwealth activity. However, the Suicide Prevention Program is the Commonwealth’s own investment program and is not funded through, or jointly with, states and territories. While a concerted effort has been made to joint planning with states under the program, it is not the mandate of the program to directly invest in state and territory areas of activity or to be the sole funder of suicide prevention activity in Australia.

The National Suicide Prevention Program funds national infrastructure and activities, such as: a centre of excellence on suicide prevention and the LIFE communications project; peak organisations and governance, including Suicide Prevention Australia, the Australian Suicide Prevention Advisory Council and the Indigenous Strategies Working Group; national activity and projects which seek to take a universal or consistent approach to rolling out suicide prevention activity, such as Mind Matters, Oz Help or the ATAPS suicide pilot; and locally based projects which usually target groups at high risk of suicide and which are supported nationally by the above infrastructure and resources. A comprehensive evaluation of the National Suicide Prevention Program planned for the second half of 2010 will enable the department to further advise the government on how best to target effort and improve effectiveness in preventing suicide in Australia.

Since the department last appeared before the committee, the ABS released *Causes of death, Australia, 2008* on 31 March 2010. The ABS is the statutory authority responsible for the routine collation of data on suicide and other causes of death. The ABS has recently introduced significant changes to improve the quality of coding specificity, responding to a number of concerns over the limitations of the earlier coding model. In 2008, overall 3,313 open coronial cases were assigned an external cause of death, of these 856, or 26 per cent, were coded to suicide. This is in contrast to 2007 when only 384, or 18 per cent, of the open cases were coded to suicide. The improved data collection will enable all governments to target suicide prevention programs in the future. For example, the latest causes of death data shows that rates of suicide were generally high among males in their 30s and 40s, with the highest suicide death rate for males occurring in those aged 40 to 44 years.

At the last hearing the committee asked the department to come back on a number of issues and questions. Several documents were provided to the committee secretariat on 8 April 2010 and some of the remaining issues which required significant follow-up and coordination across the department have now been provided to the secretariat. Again I would like to thank the committee for the further opportunity for the department to assist in this important inquiry. As you know, we are joined by colleagues from FaHCSIA and DVA, who also wish to make brief opening statements.

Ms Winkler—FaHCSIA are pleased for the opportunity to again address this Senate inquiry into suicide in Australia and are pleased to be here with our colleagues from Health and Veterans' Affairs. FaHCSIA recognises that suicide is a major public issue for Australia that requires a whole of government, whole of community response. FaHCSIA is a major player in the delivery of Australian government social policy agenda. Our major purpose is to improve the lives of Australians by creating opportunities for economic and social participation by individuals, families and communities.

Our programs target individuals with varying and diverse needs across a range of areas, including child support, communities, families, children, gambling, drugs, housing, homelessness, Indigenous people, mental health, people with a disability, carers, seniors, volunteers and women. The clients of FaHCSIA funded services are among Australia's most disadvantaged and vulnerable people. FaHCSIA's initiatives are integral to the achievement of suicide prevention outcomes, as they are often the first point of call for at-risk individuals and families.

The programs we offer play a crucial role in providing early intervention services for families and individuals from higher risk vulnerable groups, and many of the programs that we offer aim to build individual and community resilience, which we believe is core to suicide prevention. Programs also provide services that can ultimately reduce suicide risk and increase protective factors. Research suggests that being part of a cohesive and supportive family unit is an important protective factor for children and young people, helping them to better cope with any stresses or adversity they may encounter. As such, suicide prevention is embedded in the broader principles of many of our family and community initiatives. We as a portfolio are consciously adopting a community resilience-building approach to reduce the prevalence of social issues, including mental illness, homelessness, family and relationship breakdown, childhood abuse and neglect, drugs and alcohol, co-morbidity, disability et cetera—all of which have been shown through Australian and international research to be associated with the risk and incidence of suicide. We believe community resilience can be strengthened by developing programs that reduce disadvantage, support inclusiveness, educate families and communities about risk factors and coping strategies, and improve access to support services.

The department works in partnership with other government and non-government organisations to manage a range of diverse programs and services to improve the lives of Australians. It assists in supporting population health by increasing access to affordable and safe rental housing for people who would otherwise have difficulty accessing private rental markets. A number of the programs also contribute to issues of preventative health by focusing on supporting strong family functioning, helping those recovering from natural disasters or other unforeseen special circumstances, and lessening financial stress for families, the elderly, the disabled and their carers through income support payments.

The department also provides a range of services for individuals suffering from mental illnesses as well as support for their families and carers to manage the impact of mental illness on their lives. We have recently undertaken an evaluation of these initiatives to appropriately address the changing context of community mental health and their role in the broader context of mental health service delivery. A number of our programs are also designed to provide supported employment and improve access to information, advocacy and services for people with a disability so that they can develop their capabilities and actively participate in community and economic life. We have both a lead agency and a major program role in improving the lives of Indigenous Australians and working towards closing the gap by both general programs and targeted Indigenous services, with a particular focus on improving housing service delivery and employment opportunities in remote areas of Australia.

We have been working actively with our colleagues, both in DoHA and across state governments, in line with the fourth national mental health plan, to improve efforts to identify people at risk of suicide and improve the effectiveness of services. We believe that the tripartite relationship between FaHCSIA, the states and territories, and the non-government sector has proven to be a successful one, with our longstanding relationship with the community sector, and that we are able to build on this and different models of engagement to facilitate contribution and commitment to actions that will help improve suicide prevention. We will be continuing to work actively with our colleagues in DoHA in relation to the broader health reform agenda.

Mr Carmody—Thank you very much for the opportunity to appear before you with my colleagues from Health and FaHCSIA, to make an opening statement and also to answer your questions. In the Department of Veterans' Affairs we take mental health diagnosis and treatment for our clients, suicide, the risk of suicide, and suicide prevention very seriously. Over more than a decade governments have commissioned numerous health studies examining mortality from military conflicts. These include the 1997 mortality of Vietnam Veterans study, the 2005 *Australian national service Vietnam veterans: mortality and cancer incidence* study, the 2003 *Australian Gulf War veterans' health study*, and the 2003 Australian veterans of the Korean War mortality study. These studies have not provided conclusive evidence on suicide prevalence in the veteran community compared to the general population, although several of the studies have indicated increased risks for some specific groups.

The report *Australia's health 2008* noted that for ADF members, 'The rate of suicide, which is about half of that in the non-military population, is particularly noteworthy'. The study also stated:

> Another notable, and perhaps unexpected, result from the DVA studies concerns suicide. The rate of suicide among Vietnam veterans, for example, is very close to the community average.

In 2008 DVA engaged Professor David Dunt, an eminent public health specialist and epidemiologist, to undertake a comprehensive study to examine the issue of suicide in the veteran community. In 2009 the government released Professor Dunt's study and the government's response, including agreeing to the 21 recommendations. But, from my remarks so far, it is clear that research to date remains largely inconclusive as to whether or not veterans are at a greater risk of suicide than the general population. In fact, this was also one of Professor Dunt's conclusions in 2008.

Nevertheless, the recommendations made by Professor Dunt are guiding the improvement in mental health services for veterans and the ex-service community and cover a wide range of matters including suicide prevention, mental health programs, compensation schemes and administrative processes. As a result of the Dunt review, $9.5 billion of additional funding was allocated from 2009-10 to boost mental health services for veterans and ex-serving personnel. A copy of Professor Dunt's report was included in our submission to the inquiry. I would note that Professor Dunt was also commissioned to undertake the *Review of mental health care in the ADF and transition through discharge* report for the Department of Defence and that five of the recommendations of that report are in common between Defence and DVA.

As of May 2010, the Department of Veterans' Affairs supports about 160,000 veterans with one or more service related disabilities. Of these, nearly 48,000, or almost one-third, have an accepted mental health disability, and some have more than one accepted disability. The pattern of mental health conditions among our veterans is somewhat different than in the general population, and veterans tend to have higher patterns of anxiety, depression, post traumatic stress disorder and alcohol abuse. We work closely with Defence to improve their discharge processes to enable early identification and access to treatment before the effects of mental health conditions become too pronounced.

We provide health care and support, post service, to promote mental health wellbeing and prevent suicide. We ensure free treatment is available for PTSD, anxiety and/or depression to all Australian veterans irrespective of whether it is service related or not. Support is available from the Veterans and Veterans Families Counselling Service, which provides mental health services including an after-hours counselling service, outreach services to rural and remote Australians and a range of supportive group programs, including ADF transition programs.

The department's submission to this inquiry highlighted a range of available programs, which include support and training for mental health practitioners and for general practitioners. Suicide awareness workshops under our Operation Life suicide prevention strategy aim to increase suicide awareness amongst the veteran community. Operation *Life* is based on the National Suicide Prevention Strategy LIFE but was targeted to meet the specific needs of veterans and ex-service communities.

Research such as DVA's *Pathways to Care* project report, which was completed in 2004 by the Australian Centre for Posttraumatic Mental Health, indicated that some veterans had trouble accepting that they had mental health conditions. DVA has responded with programs to increased mental health literacy amongst veterans and providers, with the aim of improving help-seeking behaviours and responsive services from mental health practitioners. The department has strong links to key organisations such as ACPMH and the Centre for Military and Veterans' Health. For example, ACPMH has been contracted to provide education for secondary mental health workers, primarily psychologists, to improve the competencies of these professionals in treating veterans with common mental health problems. This training will be rolled out nationally over the next three years. We are also active in assisting veterans to reduce alcohol related harm, often a contributing factor to suicide. We have developed and recently updated the Right Mix website, which provides tools and strategies to assist veterans to manage their drinking and to seek a healthier lifestyle.

DVA continues to make a significant investment in supporting veterans with appropriate mental health care and treatment, but a key challenge is ensuring that services are available to meet the needs of each individual, including those at risk of suicide. DVA is very committed to our work in this important area. Issues such as reducing the stigma around mental health illness, increasing mental health literacy and promoting self-help, continually improving the quality of care provided to veterans and reviewing and further developing the provision of suicide awareness resources and training for the veteran community, including online options, are all important outcomes for us. We are committed to working with other key agencies in recognition that no one agency can alone address issues such as suicide prevention.

I would again like to thank the committee for the opportunity for the department to assist in this important inquiry. We would be happy to take your questions and clarify any matters. Thank you.

Senator ADAMS—I would like to start on an issue that has been raised in quite a number of submissions as we have travelled around the country. As the department is going to be involved with emergency departments in the new plan, we have heard that in a lot of the emergency departments there is nobody with specific mental health expertise for triage. Often people with self-harm or coming in with anxiety and having problems are just pushed to the end of the queue and the four-hour rule does not seem to be applicable. Some emergency departments do provide a service with a psychologist or a mental health nurse on duty so that person can be taken aside but it seems to be quite a problem. I would like to raise that issue for future thought because that might be a way to actually help these people rather than them being pushed aside and then end up perhaps back on the street and then unfortunately harming themselves. Could someone comment on that?

Dr Singer—I am the Acting Chief Medical Officer but I also happen to be an emergency specialist. You are right I think it is an area that has been difficult for emergency departments to deal with in the past, but I think they are improving. There has been quite a bit of work done on specific triage strategies for mental health clients. There has also been a lot of work recently done in improving the accessibility of mental health assessments within emergency departments. A number of emergency departments, including the Canberra Hospital down the road here where I work now, have a mental health assessment unit which has specifically trained and supportive staff.

With respect to your comments around triage I think that most places now usually have checklists that allow them to try to identify when someone is at an increased suicide risk when they are being triaged so that either they can be flagged for review by mental health specialists or alternatively the clinical staff can be advised to keep a more watchful eye on those patients. It is difficult in terms of the triage prioritisation to accurately triage mental health clients compared to those with physical complaints. I think it is fair to say that we still do not have that right, but it is an area where there has been some work done. There was quite a lot of work done a few years ago in creating a specific mental health emergency triage system that fitted in with the normal five-category system that is used for everyone else but there is still a lot of work that needs to be done. I would agree with you. I think it is an area that certainly the specialists in the area are paying attention to.

Senator ADAMS—It has certainly been raised both in the metropolitan areas and in the smaller regional hospitals. Of course, when you get down to very small ones it is a huge problem for them. What about transportation of people—this is mainly from a rural area—who are threatening to commit suicide and perhaps arrive in a very distressed state? Could you give us some indication as to what could be done for these people with the Royal Flying Doctor Service?

Dr Singer—I am afraid I do not have any particular knowledge or expertise in relation to the Royal Flying Doctor Service and how they can deal with this. There is a general issue around transporting people with a mental health problem, particularly where they need to be protected from self-harm. There are certainly a number of notable cases where people have been inadequately supervised. Obviously, over larger distances it becomes much more difficult, particularly given the physical constraints and when you are in an aircraft versus a vehicle. I cannot say that I have any particular answers around that. One thing that certainly has worked in some places is being able to use tele-medicine. The ability of psychiatrists and other mental health professionals to be able to deal with the patient in the local environment through a tele-medicine link can potentially reduce the need to transport people when it is not necessary.

Senator MOORE—Are you suggesting that is being used in suicide cases?

Dr Singer—It certainly has been for patients with more chronic mental health illnesses, but there is no reason it could not be used for suicide cases as well. When patients who have either attempted suicide or are professing suicide present to an emergency department or to a small hospital it is often the physical issues that are equally as important as the mental health ones, particularly if they have already made an attempt at self-harm. There is often a difficult balance in dealing with those issues. There are also difficulties, for example, if someone has chosen an overdose as their method of attempted suicide. There are obviously medical needs that often delay the need for transport or even delay the need for a proper mental health assessment while waiting for the person to recover from the overdose.

Senator ADAMS—During triage, with dual diagnosis, often these people seem to be missed. They are not treated very well and are once again pushed out into the corner of the emergency department. Could you tell me how the dual diagnosis is working now compared to the way it used to? Before, it was very difficult. You had ambulances chasing around trying to find a bed in a mental health area rather than in an emergency department.

Dr Singer—You will find nowadays that the majority of mental health patients, when they have an apparent dual diagnosis or where there is enough concern that there is a medical diagnosis as a predominant part of the problem, will almost always be taken to an emergency department. That has good and bad aspects to it. Obviously it means that they are with people who have the expertise in treating the medical problems. What it can potentially lead to, though, is that they are with people who are less expert at dealing with the mental health problems.

The creation of joint care units, where essentially there is a combination of both emergency medicine and mental health expertise either in a unit next to an emergency department or within the emergency department itself, will obviously allow an ability to deal with both diagnoses, preferably at the same time or at least in sequence, to prevent those problems.

There are still problems when they become inpatients, though. Again, there are not necessarily any easy answers because the kind of facility you need in order to keep someone who is at high risk of self-harm safe from themselves is not necessarily the kind of facility that works very well for close medical monitoring or medical treatment. There are often difficult compromises that have to be made in order to deal with those problems. The best way to deal with them is to have experts in both areas available—preferably at the same time—and to have a system that looks at the patient’s needs as the paramount concern and so works best for them and for the problem at hand, with the ability to transition between areas of care as the need arises.

Senator ADAMS—Something that has been brought to my notice is research into front-line emergency workers such as paramedics and perhaps those in the fire services—and, of course, ambulance officers in the smaller communities. Do you have any data on the number of people in this area that, through their own trauma in having to deal with a lot of issues, unfortunately take their own lives?

Ms Krestensen—We do not have any data on the number of people in this profession who take their own lives. We have heard anecdotally that is a cause for concern, both because of the anecdotes of suicide and because of the enormous stress that the situations place on individuals. I am aware that some of the presentations given to the committee have been along those lines. This is an issue we have discussed with states and territories; they are aware of it as well. The issue of front-line training is one of the two key suicide prevention priorities identified in the fourth national mental health plan. The subgroup we have set up under AHMAC to look at alignment of Commonwealth and state and territory suicide prevention activities is looking at getting better at front-line training and at support for front-line workers. It is a debriefing type element that we need to build in to support the supporters as well as enabling them to detect and support people at greatest risk.

The delineation of the work to date has been, I suppose it is fair to say, that the Commonwealth has put its funding into front-line training for non-health professionals like teachers—even TAFE teachers—and journalists, both at an undergraduate and a postgraduate level. The states and territories have been responsible for funding the emergency service workers and have generally had responsibility for front-line training to boost their capacity to manage suicide prevention issues. Discussions to date with the states and territories have identified the need to get better at identifying what the core elements and core competencies should be in any front-line training that is provided and the need to better identify the level of support that should be provided to the supporters.

Senator ADAMS—Probably what is happening is that these people are real specialists. I am really talking about an incident in Sydney. Because they are so busy, people seem to just be forgotten. It is hard enough for the families but it is also hard for the other people who are impacted. I think there is an underlying area there that probably needs to be looked at a bit more, whether it is the New South Wales department or whatever. It is just something to flag as we move forward—more involvement with the Commonwealth in the emergency sector of health. Perhaps it is a good time to bring it up. At least it is out there to be noted.

We had the ABS here earlier. They were discussing their role and the data collection. As we have moved around there have been a lot of queries about whether suicide is underreported. Having spoken to, and having had presentations from, some of the coroners, it appears that with the coding of a person who has committed suicide it is a really delicate area as to what goes on the death certificate, which you are all aware of. Often the people doing the actual collation of the data at the start, before it comes out of the coroner's office, are fairly junior. Because it is such a complex area, unless there has been a determination that a person actually has committed suicide, or something else has been underlined and it is not been recorded as such, the ABS said that they take the national coronial information system data—and the coroners feed into that—as gospel. So that is where their data comes from. Is an audit done? Who would be responsible for going back to the grassroots, where it first starts, to ensure that the data is recorded and coded correctly? Is there any way we can find out how that part could perhaps be improved, because if the ABS is relying completely on the coroner's office for their information and it has not been recorded properly at the start, the whole data system could be completely misconstrued.

Ms Harman—You have identified some really key issues that we are very aware of. Obviously the burden of proof is extremely high for coroners, and that is very important. Data collection, collation and the initial coding are things that the department has been working on with the coronial system, SBA and others in order to educate coroners of the importance of accurate and timely reporting on cases of suicide. The other thing that is very important in this space is the retrospective recounting of data, which has started. The latest cause of death report is showing the benefit of that in terms of more accurate data.

Senator ADAMS—But they are not going back far enough—this is what I am trying to get at.

Ms Harman—It is a three-year retrospective process initially—

Senator ADAMS—No, sorry, they are not going back to where the person is recorded as a suicide or looking at how they are coded. My observation of the information we have had is that if that data is not correct when it gets into the national coronial information system, ABS only uses that. They do not go back any further. So is there any way the audit can start before it gets into that system, going right back to the original coding?

Ms Krestensen—I am not aware of any way that we could go back to the original coding. The only thing that I can suggest here is that we are aware that in at least three states and territories there is almost a dual recording system where the jurisdiction itself also has a method of keeping a tally of what they consider to be suicides. Queensland has got a system that runs, I think, in partnership with Diego de Leo's centre—and I think you spoke to them this morning. WA is also developing its own data collection to try to have a way of validating information coming through the coronial system, and Tasmania has also been keeping its own data for several years. That could be one way of crosschecking. But in direct answer to your question, I am not aware of any way there could be a process of going back to the original records where the Commonwealth could be involved other than working through the NCIS to see whether they have any suggestions on that front.

Senator ADAMS—That would be the way, because it starts at the source—they get the information—

Ms Huxtable—There are issues of trust and standards and the audit of the coding standard. I presume this is managed through Registry of Births, Deaths and Marriages in some way, or perhaps Attorney-General's is the relevant agency—

Senator ADAMS—They said the coroner's office, and from what we have heard they have a very limited budget so they are not able to employ many. They have fairly junior staff employed. It is just something that has arisen and I thought that it was worth raising it just to see. And that brings me onto my final question—on the cost of suicide. Has the department done any economic modelling on the actual cost to the community of suicide?

Ms Huxtable—No, we have not. I think this issue was raised at the last hearing and we have since that time gone and had a forensic look at whether there is any information available that we could draw some conclusions from. But we have not been able to identify anything that relates specifically to Australian circumstances. We are aware of the New Zealand study, and I think that was referred to in the Queensland government's submission to this inquiry. I think they speculated in that submission that the study may well be broadly applicable in terms of orders of magnitude to the Australian situation. To do a proper body of work on this issue would take significant time. It would need to be allocated a priority from within a government and the normal way this would occur would be through the engagement of a body like the Productivity Commission that can apply the appropriate robust methodologies to work like this. So I guess the short answer is no.

Senator ADAMS—Thank you very much.

Senator MOORE—I am interested in a couple of the key points that have been funded in the program up to now. I have the updated list of funding which includes project 33, which is the ATAPS program. We have spoken a lot in this committee about the need for effective referrals and protection so that when people have been identified in the system they are looked after, and that seems to me to be the focus of this program.

Ms Huxtable—Senator, do you have a page number?

Senator MOORE—It is page 18 and it is project 33.

Ms Huxtable—Thank you. I do not have numbers on mine for some reason.

Senator MOORE—The numbers are in the little boxes. I am sorry, Ms Huxtable, but it is the ATAPS program. It says that this particular scheme has been funded for 2007-08 and 2009-10 across 18 divisions of general practice across Australia for crisis support et cetera. What I am trying to find out is this. At the bottom it says 'currently in negotiations'. I want to know what that means. We will definitely get to DVA, I promise you. I want to know what that one of the 21 recommendations that you agreed in principle was in terms of the ATAPS program. You might not know that one now so I will get you ready for that. What does 'currently in negotiations' mean?

Ms Krestensen—The ATAPS program is continuing for another two years. The minister has written to all of the divisions to advise them that it will be continuing. We sent an email to all divisions yesterday actually advising them they will be getting their draft contracts this week to sew them up for this next financial year. Those contracts have two tiers of funding. Tier 1 looks like the old fashioned ATAPS, the traditional approach. Tier 2 rolls in together special purpose funding which includes funding for continuing the 18 trials on suicide prevention post discharge. Tier 2 also includes some additional funds for those divisions who wish to extend their services to provide services to individuals who have been referred by a GP post a suicide attempt or referred by accident and emergency. In negotiation means that we are currently negotiating the contracts with divisions for the next financial year. The good news is that the suicide pilot is being continued for one more year. We are asking those 18 divisions to work closely with us in continuing to evaluate that trial. We have had very strong feedback. We needed a full three-year period to be able to have a look to see if that approach had worked. In the meantime, there is that broad model itself in terms of allowing individuals who have attempted suicide to access, for a short period of time up to two months, additional ATAPS services and to be referred provisionally to allied health workers immediately and to get backup support. It is a model that other divisions have indicated they would like to have a flexibility to use, so some additional funds are rolled in so that services can choose to pursue that flexibility for that group of patients as well.

Senator MOORE—This is what I cannot quite get my head around. In the original process there were 18 divisions of general practice who were part of that, which was called a trial.

Ms Krestensen—That is right.

Senator MOORE—That always worries me, but it was called a trial. It has now been extended for one year only, and this is what the contracts will say. Are any more divisions getting access to the money?

Ms Krestensen—We are not going to be expanding the trial itself, which involved quite comprehensive evaluation data collection and establishment of protocols with local government and so forth. We are not going to be asking other divisions to participate in that trial. It would also be a bit strange to do so just for one year. So we are continuing that trial just for those 18 divisions. There were originally 19. One division dropped out, so we are continuing with those 18 divisions. We are building into our additional funding for ATAPS some additional service capacity for the rest of the divisions, which is about 100 divisions, to enable them to boost their capacity to provide more services to people who have presented to a GP or have been referred to ATAPS post a suicide or a self-harm attempt. They will not be required to participate in the trial. They will not be required to undertake the onerous data collection and information provision that we have asked the other 18 to provide. But they will have the capacity to more flexibly use ATAPS funds to provide a few things. One will be additional services for that two-month period. The second will be that they can take up a provisional referral without having a GP assessment of someone who has been referred from an accident and emergency service. It gives them that capacity to provide more and flexible services to that target group. So it is about expanding some additional funding so that that model is just not contained to those 18 divisions. In some ways this is pre-empting the evaluation but we are moving down that line of that additional flexibility because the model has been seen to be what could be termed technically a no-brainer, I suppose, in terms of allowing more flexible support to those individuals who really do need that care post discharge and to enable GPs to have a bit of extra support and manage those people in the community.

Senator MOORE—So these other divisions, about 100 of them, can opt in or not?

Ms Krestensen—That is right.

Senator MOORE—Do they have to meet any requirements to access the funding and how much money do they get?

Ms Krestensen—The funding will be part of a flexible tier 2 funding pool which will be available for them to use for a range of special purpose measures. In the past we have made it fairly complicated, I have to say, for divisions in terms of our special purpose funding that had their traditional ATAPS funding and then they had various little top-up bits associated with perinatal depression, associated with bushfire support, associated with telephone and web based programs and in some cases associated with specific Indigenous projects. This rolls together that special purpose funding into one flexible pool of funds with revised guidelines associated with that pool of funds which enables them to do more innovative and flexible models of care for those very vulnerable groups. So a division can choose—or not—to use those funds for suicide prevention. They might not have a significant need. If they do they can use them as they wish in terms of the guidelines. The divisions may have, in some cases in Victoria, a greater need to focus on individuals impacted by bushfires. But it is a boosted flexible pool of funds which will enable a division to respond to the needs of its community.

Senator MOORE—So how much extra money?

Ms Krestensen—For suicide prevention the total additional funds next financial year, which are boosting the whole of the capacity of the ATAPS program in terms of suicide prevention, are $3 million, which have been approved by the minister to roll into ATAPS to boost the capacity of ATAPS to support individuals at risk of suicide, potentially those who have been referred post discharge after a suicide attempt. Of that $3 million, $1.7 million is going to extend the trial in those—

Senator MOORE—And of the trial in toto? So all the requirements of the trial—the evaluation, the reporting and the data collection—will be continuing for those in completion?

Ms Krestensen—The $1.7 million does not include the cost of the evaluation. That is being funded separately. So $1.7 million will be going to divisions to enable them where they are involved in the pilot to continue the pilot for one more year. So it is basically continuing that funding at the existing level, which is about $110,000 per division per year for that suicide trial. We are allowing them to continue at that level for one more year. The balance, $1.3 million, is going to be put into the flexible funding pool. I am sorry but I do not have a figure for the total of that flexible funding pool, but it will be available to divisions to use as they wish as part of the broader flexibility associated with that funding pool to meet the needs of the patients in their particular area.

CHAIR—And that is additional money on top of what is currently in the smaller programs—the bushfire program and the perinatal program. So the $1.3 million is new money?

Ms Krestensen—The $3 million is not new money as such but it is new money to ATAPS in that it has been allocated from the suicide prevention program to the ATAPS program next financial year to tie up this particular need.

CHAIR—So what does it come out of?

Ms Krestensen—It is coming out of the suicide prevention program funding stream.

CHAIR—What was previously funded under the suicide prevention program?

Ms Krestensen—These funds were not committed for the—

CHAIR—These were non-committed funds?

Ms Krestensen—Non-committed funds for the next financial year.

Senator MOORE—These were for future year funding of suicide prevention? So that is where it is going?

Ms Krestensen—That is correct.

Senator MOORE—So $1.3 million of it is going into that. What about the money to Crisis Support Services that came out of ATAPS? Is that being continued? Within the same little box for project 33, which is on the piece of paper that I have, it has got '18 divisions of general practice, Crisis Support Services and the Australian Psychological Society' and the crisis support funding was for a 24-hour telephone service, which was on the same funding according to this diagram.

Ms Krestensen—That has been continued also but that is a different project. I am looking down my list to see which number that is. It is No. 18. It is mentioned because the crisis support service phone line is linked very strongly to the ATAPS funding.

Senator MOORE—Absolutely. I was wondering why one was 18. I was going to ask about that anyway because it is much more than a telephone service that is linked in that little box. In this little box it is particularly to do with referral after hours. When we had the crisis support people I was asking questions about both of their lots of funding, because they got the bit that was part of ATAPS and they also got the bit which was supposed to be the kind of central depository of all services. So if I wanted to know what was going on in suicide I could ring them up and they would be able to tell me—only they could not. But in terms of this funding which is part of 33, is that bit for the telephone service going to be continued as part of the ongoing trial?

Ms Krestensen—That telephone support will be continued as part of the ongoing trial; that is correct.

Senator MOORE—Just for one year at this stage?

Ms Krestensen—Just one more year at this stage, because the contract we are entering into with ATAPS is one more year. Even though we have funding for two years, we need to work with divisions and other stakeholders to develop up implementation approaches in detail for the future of ATAPS, because we are making some fairly significant changes in the future to introduce targets and various other approaches to change the way it operates. We have an extension of one more year whilst we work with stakeholders to develop up those detailed implementation plans and future guidelines.

Senator MOORE—Okay, and what about the Australian Psychological Society—the training aspect of ATAPS? Is that being continued for one more year as well?

Ms Krestensen—We are yet to negotiate at with the Australian Psychological Society, but they have certainly made available some online modules for training, and those online services and resources will still be available. But we have yet to negotiate with the APS about that support role.

Senator MOORE—Is that funding and crisis support funding also part of the $1.7 million?

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

Senator MOORE—Sure, that is fine. I would just like to know which money is going to extend to ATAPS and how it is going to be linked.

Ms Krestensen—The answer is no, I have just been informed. Just to be really clear, the CSS project funding was separate to the ATAPS funding. The CSS got two projects of funding from us, as you pointed out. One was the LIFE Communications Organisation: Crisis Support Services Inc; the other is the one that is articulated at number 18 of your list, which is Call Back Services.

Senator MOORE—Just so I can be clear, under 33, what we were told is $4½ million went in originally in 2007-08, 2009-10. I have $4,480,876 total funding for the ATAPS program for those two periods. You have told me that is an extension for 12 months: $1.7 million of extended funding is going to go into the existing divisions of general practice to maintain the trial for 12 months; $1.3 million is going to go into flexible funding for other divisions to choose to opt in if they wish for some of the process. I just want to work out exactly what is going to happen for Crisis Support Services and the Australian Psychological Society, which were part of the pre-existing funding? What is going to happen to them in the next 12 months? You can take that on notice. I just want to see what is in that particular bucket.

Then in 18, which is the other crisis support one, under the heading here they got funding under this particular bucket, which is another one, for the safety net calls and the vehicle for monitoring and assessing the effectiveness of information referral or any other strategy suggested by the counsellor and to demonstrate and create resources which document practise based evidence of the most effective strategies for supporting families. That was that box. They are now funded until 2010-11. What is the evaluation for that one, because they will be going into the last year now of providing a service? There will be an evaluation of that particular process, which is the call back one. You talked a lot with them when they were here to talk with us.

Ms Krestensen—There are two overlapping evaluations on this one. As a largish project, as with all of our large projects, they are required to do a fairly robust evaluation of how it has worked. They are also required to work with us, given this is supporting the ATAPS suicide prevention pilot in a broad evaluation being done by the University of Melbourne of that suicide prevention pilot. There is double evaluation taking place in that sense: they are being required to evaluate their own efforts and also to feed into how that particular element of their work has worked, how effective it has been.

Senator MOORE—And the money that is there—$1,667,273—that has nothing to do with ATAPS?

Ms Krestensen—That is funding them to do what they are doing up to June 2011. That covers, as far as I understand it, the support that they provide to the ATAPS project. That is one bucket of funds.

Senator MOORE—Could we get that clarified. You do not have to do it today. I am just getting it clear.

Ms Krestensen—That is okay.

Senator MOORE—There was a tender put out over Christmas time—we actually have some worries about tenders at that time—for a new pathways project, which was looking at suicide hotspots across the country. What has happened with that tender, because many of the people who were interested in that are already receiving funding elsewhere? To the best of my knowledge that tender has not been announced yet.

Ms Krestensen—That is correct. The winner of that one has not yet been announced. We are close to finalising it, but we are not in a position to announce the outcome of that process.

Senator MOORE—Of course. I would be surprised if you were going to do that for us. I am interested in something else, and this is something you may want to take on notice as well. Communities had a very short time to respond to that tender, and it was over the Christmas period. I have raised many times before the issue of how people can get those things. Now we are in May, and there has been no decision. I know that is a ministerial thing, and we will be taking that up in other ways, but it does seem that this was looking particularly at suicide and hot spots around the place, and it was promoted in that way. We are now in May and we have not got a decision. People had three to four weeks over a very difficult time—I think it was three weeks; I have not got my stuff in front of me—to respond to that tender. Can I just get an answer on that.

Before I go to Mr Carmody—because, of course, this will cross over to you as well, Mr Carmody—I am interested in the issues around research into the areas of suicide. We have had a couple of discussions around here. I am just wondering whether anyone can let me know. I have been through these funded projects, and there are elements of research for it in a couple of places, but I am particularly interested in the NHRMC and the ARC, to see whether we can get any information on how many research projects that are linked to suicide are currently funded through the NHMRC and ARC.

Ms Krestensen—We will have to take that one on notice, but there is a planning workshop with the NHMRC and some very important mental health stakeholders coming up very soon to guide their directions in that area.

Senator MOORE—Mr Carmody, you have been very patient. I will think of something for FaHCSIA, I promise you. The DVA submission focused very much on the work that was done around the review of veterans, which I know was highly celebrated; people had waited a long time for it to come out. Your submission tantalised me by saying that you had had 21 recommendations; you supported 20 and you supported one in principle. I could have looked it up on the website, but I thought it would be easier if you could tell us which one you agreed to in principle and why that was different.

Mr Carmody—Thanks; I would love to. The recommendation that this related to was a recommendation about pension officers. It is mental health related, certainly, but it is slightly tangential in the sense that it was related to the difficulties some people face in getting their disability pension or compensation claims through the system, how complex the system is and how that causes some people a great deal of trauma.

Senator MOORE—Did this relate specifically to mental health issues or was it a general comment about the system?

Mr Carmody—It was a general comment about the system. For decades, the ex-service organisations have had a system of voluntary pension officers, volunteers who assist members with their claims.

Senator MOORE—They become advocates.

Mr Carmody—They are advocates and what have you. What Professor Dunt recommended was that we develop a two-tier system of volunteers and professionals. The volunteers would do the easy ones; the professionals would do the more difficult ones. The professionals are trained, accredited and obviously paid by someone to do—

Senator MOORE—Paid by ‘someone’?

Mr Carmody—Paid by ‘someone’. I said ‘someone’ deliberately.

Senator MOORE—They are paid some amount by someone!

Mr Carmody—They are paid some amount by someone to run through this process. He suggested that one of the possible sources of funding may be through our Building Excellence in Support Training, or BEST, grant system. Over the last 12 months, we have been reviewing our TIP and BEST training grants systems and how we provide this. That review is not yet complete. It is broader than this issue, but this issue gets picked up in it. The government accepted it in principle, saying, ‘Yes, it’s a good idea, but the devil is really in the detail of how you would do this.’ We would also have to consult extensively with the ex-service organisations, who actually have all of the volunteer pension officers at the moment, and they think they do a pretty good job—and they probably do. We would have to say, ‘Some of you we’re going to professionalise and some of you we’re not.’ That was really the issue.

Senator MOORE—Extraordinarily sensitive, I would understand that. The only other question I have is about you going into detail in describing your operation of the LIFE suicide prevention framework, which is very detailed and seems to be very effective. But that came into operation before you had the review announcement from all the work that you did—looking at particularly the ex-service community and suicide. I am wondering how the recommendations of the review then fed back into a framework that had been pre-developed. What was the mechanism for feeding in the knowledge that you gained from the review back into framework which, according to this here, you are going to have a review of in 2010 anyway?

Mr Penniall—Professor Dunt did make some recommendations around the suicide prevention programs. As you stated, that program was in operation before Professor Dunt started and it was built on and based on the National Suicide Prevention Strategy. But with extensive consultation with the veteran community we tailored that series of programs to them.

Professor Dunt concluded that many of those programs were in fact very good programs and seemed to be showing some positive impact on the veteran community in increasing mental health literacy, understanding, et cetera. He did recommend that we review some of the Operation Life workshops that are being conducted for the veteran community; specifically, a series of the assist programs. We are just about to go out to tender to get a consultant to do that review and look at those programs in the context of what is happening nationally and internationally to ensure that the programs we are running are properly evidence based and can properly meet the needs of the veteran community.

Senator MOORE—Is that review you are talking about the same one that you have mentioned in your submission or is it a separate look at the process?

Mr Penniall—I think we mentioned it in the submission, yes.

Senator MOORE—In your submission you said that the whole framework was due for a review: ‘A review of the workshops will be undertaken in 2010.’ So that is the same one?

Mr Penniall—Yes, that is what I am referring to. I believe that a review of Operation Life is also going to be conducted in the future, so we will obviously need to ensure that any changes to the national program are certainly taken into account in what we then personalise for the veteran community.

Senator MOORE—I have a question to ask the Department of Health and Ageing about project 44, which are standby suicide bereavement support services. We have had evidence in a couple of places about variations of programs that offer this kind of support, which is about resilience for communities. We had extensive evidence from a Tasmanian based organisation when we were in South Australia and also from a north Queensland organisation which I understand ran similar programs.

My understanding is that project 44, which is now funded into 2010-11, has come up with an agreed model for how these services will be operating and that the people who have won the contracts have a model that the department now prefers for offering the services. Is that right? On page 24 of this it says that a two-year independent evaluation of sites found that the StandBy program was very effective. As a result of that two-year evaluation, has that led to a decision by the department that for this particular service that is going to be the preferred model?

Ms Krestensen—There has been no decision that that would be the sole bereavement support project we will ever fund, just to be clear. It has been the case over the last three and a bit years that it has been one of the approaches we have had the opportunity to systematically roll out nationally. I guess that process started back in 2006 when there was an open competitive process and four projects were put in by local organisations supported nationally by the StandBy model. There was a chance to have a look at how that rolled out in four locations. With the need for additional bereavement support in places like the Kimberley and in Tasmania, there were opportunities that were negotiated with the state government to expand that model to those areas too.

The evaluation has shown us that it is a model that seems to work well. As you have suggested, we do fund other bereavement projects in other places, so we are not at a point where we are saying we will only ever fund that particular model, but it is one model which our stakeholders have given us good feedback on as being one that works well. It is one that has been evaluated and we have been provided with some fairly rigorous information on the effectiveness of the model, given it is a coordinated approach to providing a range of services to people who are bereaved by suicide. But I suppose you could say it is not the only horse we are ever going to back, in that there are other projects which might meet local circumstances a bit better.

Senator MOORE—This gets back to a question we have had many times as to the difference between an organisation which is well-established and has a history of providing services and a local organisation that has been operating in a region and then, when a tender is offered, the larger organisation which has no links with the local area wins the tender because of its proven record somewhere else. I know this is an oft-asked question, and it is a really bedevilling issue in that so many of the projects which have been funded through this scheme in the past couple of years have been localised. But in terms of the future, we have had evidence from a number of smaller organisations, it would be fair to say, who have felt that when it comes down to ongoing funding, when it gets beyond a one- or a two-year introduction, they are considered not competitive against someone who is from a completely different part of the world who then gets the bigger tender and then has to recreate services locally.

I am not sure what the answer to that is, but it was particularly evident in the suicide funding. People came to see us, talked to us in local areas because we were lucky enough to go to a couple of regional areas linked with other committees, and it came up a number of times. It comes back to the issue: what is the requirement in a tender, and it probably comes across all of your departments, if someone is setting up a services in a part of Tasmania or in North Queensland or in northern Adelaide to prove to the department, when they are putting their tender in, that they have the ability to work locally and have local partners? With this one here, project 44, the way this reads is that a number of organisations have now picked up tenders across the country. I am not going to pick one, because it is too difficult, but just say I am a company that is based in one part of the world, I am putting in a tender to work in North Queensland, which is a localised area. When I put that tender in, what is the requirement to indicate that I have local partners, that I am able to hit the ground running and put the work into place?

Ms Krestensen—The only open tender process we have had for local community grants was run in 2006, and you are quite right: there was some concern from smaller organisations who were not as good at writing submissions as bigger organisations. At the time there was an attempt to try to provide an opportunity for small projects as well as large ones because there were two types of grants that there was an open process run for: there were the three-year big grants and then there were the very small local one-year projects. That did not seem to hit the mark in that it still did not address that problem—that is, the best written submissions were funded rather than necessarily what was needed. So there were two dimensions to that problem. One was that worthwhile small projects felt they could not compete. The other problem was that the funding was not really targeted to where it was needed. We had to make adjustments after that because we found that through that process there was not sufficient funding provided to the Northern Territory, for example, because they did not have projects provided because their submission writing skills apparently at that point in time were not as good as some other areas of Australia. That was the other problem.

In terms of the more recent experience, there has been some confusion about what happened last year, which is understandable. There was not a further open tender process. What happened was those three-year community grants which had been funded through that open round back in 2006, which was just after the extra COAG money came in for suicide, came up for completion. They had run their full course; they were required to provide reports to us and do mini evaluations. A decision had to be made with what we were going to do with those funds for the following two years. We were getting the very strong signal from the sector: ‘Don’t do this stop-start stuff to us. There’s some good projects out here. Where these projects have been going, give them a chance to run longer.’ So the game plan, which was negotiated with the minister and ASPAC, was that there would be criteria applied to all those existing projects to see if they continued or not. If they had proven to be effective, if they were meeting a real service delivery need or a particular client group that was high needs, such as Indigenous, but where they had shown some promise and done well—and where the project wanted to continue—they would go forward and we would give them the opportunity to extend for another two years, up to Jun2010, at the conclusion of the COAG period.

Where those projects had completed what they wanted to do, did not want to continue and in a very small number of cases where there was an assessment both by our state office which manages these projects and by state health that the project, whilst it had run its course, completed the full contract, had not really achieved what it had hoped to do, there was a decision not to offer those organisations continuation for two years in. In those cases there was a very small amount of funding which was negotiated with states and territories and applied to key priorities in the states and territories. The project I think you are talking about in North Queensland is one where it had been evaluated to be a successful project and involved a local partner and a national organisation. It was given the chance to continue. The key message was where these projects would continue we were saying to them, ‘We’re happy to fund you for another two years doing what you have done because we have evidence that it has worked relatively well.’ We on all occasions were not in a position to say to the organisation, ‘Thanks for that, would you like to do something else for another two years?’ The criteria and the approval were that we could continue these projects which had been effective for a further two years, and in that particular circumstance the local organisation did not want to continue as the local partner with the national organisation and a further approach was needed to work out what we were going to do with that particular project.

It was not an open tender process but both the partners put in proposals and, given that the game plan was continuing what had proven to work for those two years in that case, given that was the mandate we had at that point that is what led to that process. But it was not an open tender process. The only open tender competitive process we have had for community grants has been back in 2006. We have not run one since because of the feedback we had about the need to better target to the geographic areas, to the groups, to where the limited suicide dollars were needed, rather than just a scattergun confetti approach. We have, of course, got the tenders going at the moment for the national projects such as the Pathways to Care project and the Hotspots project, but we have not run any further tenders. We will be working out what we want to do in terms of future local funding as a result of the evaluation and I am sure the results of this committee’s deliberations will also help to inform that. But we have the current projects in place up to June 2011.

Senator MOORE—The new round of tenders have closed; the Pathways one closed months ago. In terms of the deliberation around those in terms of the threshold issue about local knowledge and local engagement, is there an element in that tender, if it is going for a regional area, that indicates proven links with that region before they can win the tender?

Ms Krestensen—The answer is probably no because these are not local projects.

Senator MOORE—But they will be in localised areas, won’t they—suicide hotspots, for instance.

Ms Krestensen—It is really a national project to get some national expertise and guidelines and protocols. It is not looking at actually examining local area issues. So there was not the requirement to have a local partner to roll out activities at local level for either of those projects.

Senator MOORE—Is that a requirement in any tenders, to have a localised partner?

Ms Krestensen—I think you have made a really good point, that where there is a project that has a local presence we need to have the local engagement of that community. The project for North Queensland has a local partner. Lifeline in Cairns is the local partner for that project. It was a requirement that they have a local project partner.

Senator MOORE—So that is actually in the tender document.

Ms Krestensen—It was in the criteria for evaluating whether we continue that project.

Senator MOORE—Was it in the tender document?

Ms Krestensen—There was no tender document for the project.

Senator MOORE—In the tender expectation.

Ms Krestensen—It was in the expectation delivered.

Senator MOORE—I have the same question for projects that are locally based operating in FaHCSIA—the PHaMs one is a perfect example. Even though PHaMs is not focused exclusively on suicide, it is a perfect example of a local project. Is there an element in the tender process which indicates that if someone is going through a tender in Kalgoorlie—I am trying to be safe here—they would have to have partnerships in Kalgoorlie within the process so that they could start on the ground?

Ms Winkler—You would be aware that we ran a number of processes for the implementation for PHaMS?

Senator MOORE—Intimately aware, yes.

Ms Winkler—The final round—PHaMs Round 4—has been completed in the last couple of months. Those locations were identified in consultation with the states and territories around areas of high need. As part of that process there was also identification, so it was not an open selection process. There were providers identified who were already offering some level of service within the identified communities and they were invited to apply. Within that process they still then had to demonstrate how they were going to effectively service whatever the client population was within that area.

CHAIR—Sorry—I am going to be painful and go back to funding. I have a list of questions which, hopefully, we can get through by the end of this session. Going back to the ATAPS funding and the Better Access funding: there have been some significant changes made in the budget to the Better Access funding. I believe that is relevant to access to mental health services. Could you explain to us what is happening under the announcement which was made last week around Better Access funding and how the department sees that as providing better services for mental health?

Ms Harman—There was a budget announcement last week about the direction of some funding from Better Access towards new care packages for people with severe illness using the ATAPS infrastructure. That will involve OTs and social workers being taken off the Better Access items under the MBS. The funding which would have been streamed through that particular gateway will be reapplied to fund the care packages.

CHAIR—Could you tell me how much that is?

Ms Harman—It is $52.6 million over four years.

CHAIR—That is coming out of Better Access?

Ms Harman—That is right.

CHAIR—And it is going into ATAPS?

Ms Harman—It contributes towards these new care packages. We know that there are a significant number of people with more severe mental illness who are being treated in primary care alone. The government’s decision was about making sure that those people are actually better cared for within primary care. We know that fee-for-service arrangements do not always suit that particular client group as effectively as care packages. We know that there are a range of other clinical and non-clinical needs which those particular people have and that systems like Better Access cannot actually reach out and care for those people in the way that they necessarily need it. The six-plus-six sessions under both Better Access and ATAPS are not necessarily the right modality of reaching out to them.

The new funding will be directed towards individualised care packages. They will be tailored to people’s individual needs and they will involve multidisciplinary teams, including social workers and OTs. We see them as absolutely fundamental to the success of these new care packages, and they will provide ongoing care for these people in the community.

CHAIR—What evaluation process was done on the Better Access program to look at whether it had been effective? What evidence base are you using to pull the money out of Better Access to put into ATAPS, rather than delivering more money to ATAPS and keeping Better Access going at the same level of funding?

Ms Harman—The evaluation of Better Access is currently underway. That is due to report to the government by the end of this calendar year.

CHAIR—So why pull it out now, before the evaluation is done, including to ATAPS?

Ms Harman—That was a decision of government.

CHAIR—Did you provide advice to government on that? I am not going to ask you what the advice was—I know I am not allowed to—but I want to know whether you gave it.

Ms Huxtable—Clearly, we provided advice across the whole of the health reform package, and this is part of the health reform package. It would not be the only area where there were changes made at the same time that new money was put on the table. I can provide other examples where offsetting savings were realised and monies then redirected to other related activities.

CHAIR—This was about savings, not about providing better care?

Ms Huxtable—No, this was not. And that is not what I said, Senator.

CHAIR—You said 'where savings were made'.

Ms Huxtable—I said that there are a number of areas across health reform where, within different policy areas, new moneys were put on the table and, in part, there were savings made at the same time to fund some of the new moneys that were put on the table. That does not entirely make sense. I will give you an example: in the practice nurse incentive changes, a certain amount of money has been made available to provide incentives for practice nurses across general practice. In part, that is being funded by no longer having it before and on behalf of GP items that practice nurses had available.

CHAIR—Sorry—no longer having?

Ms Huxtable—Those specific practice nurse MBS items that have been around for a few years now. There was a decision that that was a more effective way to provide support in respect of practice nurses reaching a broader range of practices et cetera, and so there was an offsetting saving that contributed some of the cost of that measure. Similarly, here, the government came to a view that the $58-odd million that has been put into the ATAPS was, as Ms Harman said, a way to address the needs of a group of people who were not being well treated within the primary care system, in particular and that, as part of the funding for that, a small amount of money would be redirected from Better Access. This is a very large program, as you know, which has grown quite quickly over the years since it was instigated in 2006. That was basically a decision of government as part of health reform.

CHAIR—I am not for a minute disputing that people require care packages and that people with high needs should not have their needs met. What I have concerns about is pulling money out of Better Access before the evaluation process has been done and before we know whether the services provided by social workers and OTs were in fact meeting the needs of another group of people—a different group of people—who were accessing those services. On what evidence was the decision made that the services under Better Access were not providing the people who accessed them good outcomes?

Ms Huxtable—I think this was more about whether that money could be used more effectively in respect of a different group of people.

CHAIR—So it was a decision that was made without the evaluation process being undertaken?

Ms Huxtable—Clearly, the evaluation process is not complete. It was not made following an evaluation. That having been said, the evaluation has been in train; it is underway.

Ms Harman—It has been underway for about 10 months, I believe.

CHAIR—It is due to report shortly?

Ms Harman—It is due to report. There are four or five different components to the evaluation. It is very comprehensive and the summative evaluation of all the different components will come together at the end of this calendar year.

CHAIR—That will go to the minister, and then the minister will determine when that is released as per the usual process?

Ms Harman—That is right.

CHAIR—So we may not see it until the end of the year?

Ms Harman—That is correct.

Senator MOORE—Has the evaluation looked at access in regional and remote areas? One of the ongoing things that we have been looking at since Better Access started has been regional and remote servicing. The 14th Better Access report—the reports keep coming—indicated that there were fewer referrals in rural areas than there were in urban areas. In fact, it has a spiked history. The 14th report is quite concerning. The 15th report is due, I think, in June? Is it the 15th report that we are looking at?

Ms Hart—Yes, they are regular reports. I suppose there are a couple of things here. One is regular reports on the use of MBS items by the different provider classes and looked at by regional and remote access and metropolitan access. That provides an input and throughput measure of how things are going. The evaluation will try and look at the picture overall and the historical picture since November 2006. As we all appreciate, fee-for-service medicine does have its limitations, particularly in rural and remote settings, so the other thing that we are keen to look at is the extent to which another program we run—which provides, through capped funding arrangements, mental health services in rural and remote settings—is complementing the Better Access program. An evaluation of that program is also under way.

Senator MOORE—Which one is that, Ms Hart?

Ms Hart—It is called the Mental Health Services in Rural and Remote Areas program.

Senator MOORE—Yes, we have had evidence on that.

CHAIR—When is the evaluation due?

Ms Hart—I think that report is due a little earlier—October to November this year, from memory. I think it is important to consider those together because we know that there are some limitations on Better Access in MBS funding. That was set up originally weighted by rural and remote location and underuse of MBS items to remedy that situation.

CHAIR—The Mental Health Services in Rural and Remote Areas program report is due in September or October, but it will not be publicly released for a while, one presumes?

Ms Hart—That is right. I think it is due in October to November from memory, and then it will go through the normal processes of going to the minister for her approval to release it.

CHAIR—Going back to the issue of funding changes, you provided advice to government on that change. Was the change suggested by the department or were you asked to provide advice on proposed changes? I am not asking for the advice, I am asking you to tell me how the process worked.

Ms Huxtable—We will probably need to take that on notice. There was a lot of to-ing and fro-ing around the whole range of health reform measures. I could not say off the top of my head exactly what the order of advice was. It was a very busy period, as you would understand.

CHAIR—I can appreciate that. If you could take that on notice that would be appreciated.

Ms Huxtable—Yes.

CHAIR—How are you proposing to action those funding changes? I am not going to get much further with the advice on Better Access so I will not pursue that—besides, we have estimates, which of course we look forward to.

Ms Huxtable—Yes, I knew you would.

CHAIR—What are the time line and the process for the changes needed for the new care packages under ATAPS?

Ms Harman—We are looking to progressively implement those care packages from October this year.

CHAIR—What is the plan for rolling those out in terms of access et cetera?

Ms Harman—That is the implementation project that lies ahead of us now. We have a series of things that we need to do including talking to key stakeholders about the shape of the packages, how we can maximise their effect, the referral pathways and all of those kinds of things.

CHAIR—None of that detail has been worked out?

Ms Harman—The detail has been worked out at a high level, but now we are into rolling out the actual measure. Like with any budget measure, we are in that process.

CHAIR—I am looking at the rest of the ATAPS program and what we have just been talking about as well as how it will complement the rest of the ATAPS process and how it will link in with the evaluation process that will be undertaken.

Ms Krestensen—The email we sent to divisions yesterday touched on this issue. It said, ‘You will have heard in last week’s budget that there is an exciting new development on the horizon—’

CHAIR—To the 18?

Ms Krestensen—To the 118; all divisions.

CHAIR—So this is the one that was sent everywhere, that talked about not only the extension of the current trial but also the other programs?

Ms Krestensen—That is correct. It is basically—

Senator MOORE—It might be easier if we got a copy of the email that went out.

Ms Krestensen—I would be happy to provide that.

CHAIR—That would be great, but could you give me the bare bones of what you said about this process?

Ms Krestensen—Yes. We have made it very clear that the contract negotiation we are doing with the divisions on this new tier 1 and tier 2 thing does not include the new ATAPS. There will be negotiations and discussions. That will be a separate arrangement that will be entered into with the divisions once we have, as Ms Harman outlined, the implementation detail work through of stakeholders.

CHAIR—What is the time line for consulting the stakeholders, and who are the stakeholders you will be consulting? Has that been worked out?

Ms Krestensen—I guess we will be consulting with our traditional stakeholders in ATAPS, which are the Divisions of General Practice; the AGPN; those organisations representing the allied health professionals; the Association of Social Workers; the OTs, given that they are already eligible providers within ATAPS; and, of course, the college of psychologists, the APS. In addition to that we will be talking to NACOMH—the National Advisory Council on Mental Health—and various other players. But, as Ms Harman said, it is early days. We have not yet got an implementation plan agreed with stakeholders to take forward, and we are very keen to have that consultation process in place before we go too far.

CHAIR—I have a detailed question about the guidelines on professionals who are able to access both Better Access and ATAPS. Where do I find that information? I do not expect you to give it to me now. Can I find that information on the website?

Ms Krestensen—The best thing to look at would be the ATAPS guidelines. We can point you to the section in that which outlines how the two measures work together and the protections against double dipping, for want of a better term, and also the flexibilities which, particularly in rural areas, have worked quite well. Providers in rural areas have worked part-time under ATAPS, under salaried secure arrangements, and then had the capacity to do private practice on, say, two days a week. We certainly allow those flexibilities within very clear parameters. They are not allowed to charge twice for the same service to the same patient and those sorts of things. We will provide you with the guidelines and the page references.

CHAIR—That would be appreciated. I can come back to this issue in two weeks time, so I might move on to a couple of Aboriginal and Torres Strait Islander issues that have been raised with us during this inquiry. We had evidence this morning from the Institute of Suicide Research and Prevention around a report they have done for Queensland on suicide in Aboriginal communities. Have you had access to that report or discussions with the Queensland government? It sounds like significant research. From what I can gather from our discussions this morning, it could have some implications for the way the issue is handled for Indigenous communities. Have you had any discussions with the Queensland government about that or have you seen that report?

Ms Krestensen—We have not had direct discussions with the Queensland government about it. Diego De Leo, who presented to you this morning, is on the Australian Suicide Prevention Advisory Council. I am fairly confident that he presented to ASPAC on that piece of work. Unfortunately, that was not when I was there to see him present. I know that he did present on the research he has undertaken on Indigenous issues but I am not directly familiar with the detail of that report.

CHAIR—I will have to take it up with Queensland. The report has not been released. I am keen to ensure that it is released and also that its findings have been taken into account.

Ms Krestensen—Absolutely. We would really like to get Diego to meet with our Indigenous Strategies Working Group, which advises us on Indigenous suicide and mental health issues. I understand that Diego wanted to have an information exchange with them about what he knew and about what they knew, and I think he would be talking to them about some of that research as well. We have not made that happen yet, but that is on the agenda for a future ISWG meeting.

CHAIR—Thank you. That takes me to an issue that has been raised in a number of submissions, the need for a separate Indigenous suicide prevention strategy. I must admit that I have been tossing up in my own mind about whether we should have a separate one or whether it should be included as part of the existing strategy but as a whole sub-area. Basically, the evidence is that we need a much more beefed up approach and that there are significant differences, as you will be aware. Have you given that consideration? How is that discussion going? Has that been raised in the discussion? What is your feeling about the need for a separate strategy or how it should be handled?

Ms Krestensen—I am going to defer to my OATSIH colleague in a second, but before I do that I am just going to say that one of the key actions of the fourth national mental health plan was about the proposed redevelopment of the Indigenous social and emotional wellbeing framework. There is a little bit of attention for me in terms of how many frameworks we can and should have. That would be a matter for us to take advice on from the ISWG, but we have always been advised by the ISWG and many others that, in terms of Indigenous mental health and suicide prevention, it is the broader social and emotional wellbeing agendas which need to be looked at, and going specific can be risky. Having said that, I would be the first to agree that we need to get better at what we do in terms of Indigenous suicide prevention. If that is a particular issue that the ISWG wish to speak more to us about, we would be happy to talk to them about it, but I think there could be some confusion if there is an overarching life framework document which alludes to Indigenous issues and there is then a social and emotional wellbeing framework for Indigenous people and then a further document. So I think it needs to be subsumed into those things in some way. But I would be very interested in OATSIH's view on this one.

Ms Saastamoinen—We in OATSIH have not been looking specifically at a separate Indigenous suicide prevention strategy. As my colleague mentioned, there are tensions between addressing Indigenous suicide prevention in and of itself and addressing issues around the broader social and emotional wellbeing of Indigenous Australians. The feedback we have been getting in OATSIH is that we really need to contextualise Indigenous people's social and emotional wellbeing within a broad range of other drivers such as access to employment and educational opportunities and the addressing of issues around intergenerational grief and the trauma of displacement from land. We are keen, I guess, to get views from key stakeholders about whether or not we need to do something separately for Indigenous people, whether it be around social and emotional wellbeing more broadly—as with the framework that was referred to—or Indigenous suicide prevention. With the Mental Health and Chronic Disease Division, we are planning a workshop between the National Advisory Council on Mental Health and the National Indigenous Health Equality Council in the middle of the year to basically talk through what the key issues around Indigenous mental health are and to get some ideas for how we could strengthen the approaches to Indigenous social and emotional wellbeing and mental health. So hopefully out of that we will be able to look at the way in which we can use the existing resources to better target programs for Indigenous people and communities and also look at how these issues can be addressed through things like the fourth national mental health plan and at what cannot be addressed through that—what we might need to do specifically for Indigenous Australians.

CHAIR—While I do not disagree with anything that you have said in terms of the social and emotional wellbeing , certainly—it may just be because we were up in Darwin yesterday, so it is very fresh for all of us—there was a sense that there are some more immediate problems. While I absolutely agree with the need to address the long-term drivers, I definitely got the sense that there was some need for more immediate response and more immediate specific strategy to deal with the current situation. That is certainly the sense that I got.

Ms Saastamoinen—Yes. For example, we have recently received a proposal from the Australian Indigenous Psychologists Association around offering cultural competence training for non-Indigenous psychologists. I know that they gave evidence at the earlier hearings about the need for cultural competence training and awareness amongst non-Indigenous psychologists because of the smaller number of Indigenous psychologists that are around. We were able to let AIPA know yesterday that OATSIH is prepared to fund them to deliver cultural competence training to non-Indigenous psychologists. We are starting off with eight to 10 workshops. It is not just the cultural awareness but also how to deliver culturally competent mental health services to Indigenous Australians. So you are right: there is a need to address some issues immediately. Where we have the funding capacity we are prepared to look at those types of proposals.

Senator MOORE—Where is that funding going to fit?

Ms Saastamoinen—That is coming out of the COAG mental health measure. Underneath the COAG mental health measure we have in our OATSIH just over $20 million over four or five years. Underneath that, the initiatives that we are implementing are a focus around training—so either mental health practitioners or workers in health services that might be having to deal with Indigenous people that present with mental health. It fits quite clearly under that strategy to provide some support to AIPA as well.

Senator MOORE—So that is similar to the funding that was in the ATAPS program for the Australian Psychological Society. When you read what is under ATAPS for the APS, it says it is funded to provide suicide prevention specific training and professional development for allied health professionals participating in the program. The way you describe it, you could just input appropriate cultural sensitivities and run a sentence just like that under another bucket of money.

Ms Saastamoinen—Ours is broader. It is not specific to suicide prevention. It is around mental health and social and emotional wellbeing. So, again, perhaps it is having more of that focus on the specific issues that have caused trauma and mental health issues for Indigenous Australians. So it is not suicide specific, but it does—

Senator MOORE—But it includes suicide.

Ms Saastamoinen—I will have to check the proposal from AIPA to see if it is suicide specific. What it generally tries to do is provide a much broader context than just suicide prevention. It is, for non-Indigenous practitioners, about understanding what are the drivers for Indigenous mental health and how they might be able to address that in their practice.

Senator MOORE—It is just important to say this, and I am sure they will raise it. When they gave evidence to us they said that one of the issues around suicide in the community was a particular lack of knowledge in general providers. When they gave evidence one of the things they said was that there was an absolute need for more knowledge about the impact of suicide in Aboriginal communities. I am just hoping that in the overall package for mental health and wellbeing, which is absolutely important to the issue, suicide particularly is included.

CHAIR—That issue then goes back—and I do not mean to harp on it—to the comment from Professor De Leo this morning around different mental health drivers for suicide in Aboriginal communities. Although Aboriginal communities, as we know it, have the same mental health issues, the broader issues of depression cannot be classed—I hope I am paraphrasing him correctly here—as mental health issues. There is the underlying sadness, intergenerational issues et cetera. In relation to what you are talking about—the issues that have been raised in this Queensland report and the funding that you are providing—it seems to me that would be really good evidence in which to provide some of the additional training.

Ms Saastamoinen—The other thing you might be interested in is that as part of the COAG mental health measure, again, we are finalising a resource book on Indigenous mental health that will be launched in time for semester 2. That is written from the perspectives of Aboriginal and Torres Strait Islander peoples. It is in its way a groundbreaking resource because it does talk through, again, those issues about the history of settlement in Australia and what that has meant in terms of impacts on Indigenous peoples’ social and emotional wellbeing and mental health—the disconnection to land, the issues around depression, the loss of family connection. There are about 21 chapters that it goes through. These are written by experts. A lot of them are Aboriginal or Torres Strait Islander people themselves. It will be placed on the suggested reading lists of curriculums of tertiary courses that have a mental health focus. There has been quite a good response from some market testing with previous students that this is the type of resource they would dearly like to have had when they were going through their tertiary training.

CHAIR—That takes me to an issue which was raised again yesterday. When we were in Darwin—I do not know if it is too strong a word to say ‘complaints’—there were issues raised with us about not just culturally appropriate materials but materials that have had to be rewritten specifically for an Indigenous context which went more broadly to concerns raised that some of the programs lacked the flexibility to be able to address the specific needs of, for example, the Northern Territory and, more broadly, Aboriginal people. Has that been raised with you and, if it has, what has been your response?

Ms Krestensen—I will start on that one. We did the early work a few years ago to develop an Indigenous specific mental health first aid resource which Tarja’s area has subsequently picked up and rolled out through some of their training to allied health workers and others. That points to successes where we have succeeded the most in terms of an adaptation of an existing resource to a culturally specific resource. In broad terms there is a need to be able to do that better. We do not have a simple solution. It is an issue we have discussed with the ISWG on many, many occasions. It is something we have to try to build into the mainstream as well as to our specific suicide prevention programs. That is one example I can point to where we did actually seem to have some success in that particular project.

Ms Saastamoinen—In the core or primary health care funding that we provide through OATSIH to Aboriginal medical services and others there is the capacity for health services to use that flexibly to address the needs of their local communities. I am aware that around 94 per cent of the OATSIH funded primary health care services have reported—I think was in 2008—that they did deliver some form of mental health or social and emotional wellbeing service delivery to Indigenous Australians. The majority of that was short-term counselling or short-term interventions, but there was also the provision of some family support services and longer term counselling and intervention.

The primary health care funding provided by OATSIH does provide that flexibility for primary health care services to target it, if they need to, to areas around social and emotional wellbeing and mental health. Bringing Them Home and Link-Up are the two direct service delivery programs that OATSIH manages around mental health and social and emotional wellbeing. There are guidelines in place for the Bringing Them Home program. They are still reasonably flexible in terms of the will to address the needs of individuals that may present but there are some expectations about the provision of counselling services and the eligibility for those services. The eligibility again is fairly broad. It is for first-generation stolen generation members plus their descendants and family members so that does cover a fair few Indigenous Australians. I would consider that to be reasonably flexible, but I have not heard the comments or feedback that those programs are not.

CHAIR—Thank you for that. My impression was that it was more for the programs that are funded under the mental health program and for the suicide specific strategies under the suicide prevention program. It was more about those programs I think. They did not actually say that but certainly from the turn of the discussion that is the impression that I had.

Ms Krestensen—I think you met yesterday with the General Practice Network of the Northern Territory.

CHAIR—Yes we did

Ms Krestensen—We are funding them to roll out culturally appropriate suicide prevention manuals for use by Aboriginal health workers. That is the sort of thing we see as being a step in the right direction. We certainly try to work in remote areas through the ATAPS delivery and so forth to get culturally appropriate methods of outreach services working with subcontract arrangements with local Aboriginal medical services and so forth. There are a few examples we can point to, but probably there should be more.

CHAIR—The General Practice Network raised comments about the general short-term nature of funding and the need for longer term funding. That is an issue for government and we should be raising that with the government. But they did raise a specific issue around the Daly River project when we asked them for an example of where there had been a problem of short-term funding. They said they were just getting that effective and running well when they were running out of funding and there was a problem for them trying to get funding. The Territory government told us yesterday that they had never said they would provide the funding, so there is a bit of confusion around who is funding what. Can you take us through very quickly, as we are running out of time, what the project was funded for and what you understand about its ongoing nature? Do you have to take that on notice or can we talk about it straightaway?

Ms Krestensen—We will give you the detail on notice. In summary, it is fair to say it was one of the very small number of projects which were not continued. We did not take lightly, as you can imagine, the decision to not continue an Indigenous project. We consulted with the state government and with our local office there, which manages these projects, but there was not evidence that we had achieved value for money through the project. It had run for close to three years. There were negotiations also with the GP Network itself to divert funds into the project I have just spoken to, so to use those existing funds instead to fund something else and take a different approach to suicide prevention in the Northern Territory. I will get some more information on that and provide it on notice.

CHAIR—That would be appreciated, if you could. I appreciate your comments that there may have been lack of evidence to suggest its effectiveness, and I do not know anything about the project so I cannot say whether I know it is successful or not, but if you could also provide any evaluation process that you undertook or that the network undertook and provided to you would be useful.

Ms Krestensen—Certainly.

Senator MOORE—It is evident from the way they described that project that it was actually a diversionary program rather than purely a suicide prevention program. This committee over many years has been interested in looking at funding for diversionary programs which has mainly been through a combination of FaHCSIA and a bit of OATSIH. I do not think I heard anything in your opening statement about youth programs and diversionary programs as such.

Ms Winkler—In our submission we made some reference to the range of projects, because we are not funding necessarily in a consistent way across the country. There are a range of projects that are funded specifically in the Northern Territory around youth activities, but they tend to be localised and some of them are short-term funded. So there is not a consistent national approach in that sense. With our Personal Helpers and Mentors Program, you would be aware that we have now got a number of sites that are being established in Indigenous remote communities. It is our intention with those that we are doing a second phase to our evaluation of the broader program that is going to focus on the remote and Indigenous elements so that we can take the learnings from that process to inform broader service delivery. Those remote sites in particular do not have some of the restrictions of the mainstream services. They can service a younger age group, a broader population, so we will be wanting to look at what the learnings are from that. There is also the broader Healing Foundation, which commenced operation late last year. Their first round of grants just closed, on 7 May, and they are looking at a range of activities that support the broader community in recovery and in their broader mental health. But we will continue to have a pool of funding within the department that is project service delivery funding that is very localised so that, through our ROCs or our ICCs, it is for ground-up development with the community around those issues.

At the previous time we met there were also some questions raised about the Blank Page Summit on Suicide at Billard. There is another forum happening in that area in July this year and invitations have gone out. The department is supporting that process with $100,000. That will be a follow-up to the work that was done last year. A lot of the work is being progressed through the local plans for each of those communities. That is really to say that there is further activity happening in some of those places.

CHAIR—Could you tell us what the time line is for deciding how the new step-up step-down funding is to be made available. We heard about the Life House project this morning, which was another initiative that the Australian Institute for Suicide Research and Prevention raised with us. I am wondering whether you have discussed the concept of Life Houses, which sound like they are slightly different to the step-up step-down process? If the guidelines are broad enough, would they include something like the Life House project? If you cannot answer it now maybe you could take it on notice.

Ms Huxtable —I can respond on the subacute care announcement, which I presume is the COAG related announcement that you are referring to. As you know, there was $1.6 billion made available through COAG and announced in the budget to support 1,300 subacute beds. That money begins to flow next financial year. We are in early discussions with the states. There is an implementation group across the range of these investments which met for the first time last week. We will be working with them around the implementation plans for these beds and then we would anticipate that there would be a national partnership agreement of some type to oversee this. The work is beginning now. There is obviously a huge health reform implementation effort which is now beginning to kick off and so that is a part of that. Clearly, in the communique that was released at the time of COAG, it was noted there were a range of target groups in respect of these subacute beds, including people who have mental health needs coming in and out of hospitals. They are very much part of the target groups for these services.

CHAIR—If I understand you correctly, what you are saying is there are still ongoing negotiations about what the criteria are, what they are going to look like and how they are going to be provided. Is that right?

Ms Huxtable —Yes, that is right.

Ms Harman—We will have to look at the Life Houses issue and see if we can map that.

CHAIR—If you could take that on notice it would be appreciated. Finally, I presume the consultation process is with the states?

Ms Huxtable —We are also talking to the states around some of those stakeholder and communication issues. There has been a National Health and Hospital Network transition office set up within the department, headed up by one of the deputy secretaries. He is working very much around the range of initiatives that need to be rolled out and certainly the way in which stakeholders are engaged is a part of that. There is also an ongoing process with the states that is already underway that will also look at those issues.

CHAIR—I know I will be exploring that during estimates, so I will leave it there.

Senator MOORE—Consistently through the evidence there has been concern about having an education or community awareness campaign. I am sure it impacts on your clients, Mr Carmody, as well as the people from the Department of Health and Ageing and FaHCSIA. No-one has explained how it should work, but it has been a common demand that there is not sufficient community awareness or education through the media about suicide. Have any of the departments, through the advisory committee to the minister or whatever, looked at how that would operate? It is certainly something that has been talked about.

My second question is on the issue that many people raise in that they do not like to see suicide linked exclusively to a mental health issue. That has come up all the time. I know that, because of structure in departments, you have to fit everything in and you cannot have different sections all around the place. However, the concern has been raised a lot that every time issues around suicide are discussed the discussion immediately goes into issues around mental health, which we have done again today. All your opening statements went to all the programs you are running on mental health. That is an issue. We have heard consistently that many people who take the decision to commit suicide have never had any links with any mental health service provider. How do the departments respond to the concern within the community that, from our governmental position, we always link suicide with a mental health issue? I am happy for you to take either of those two things on notice. I know it is difficult when you are talking about community awareness and campaigning around such difficult issues, but there has been consistent evidence that everyone thought someone should do something about.

CHAIR—Does anyone want to respond now or would you like to take that on notice?

Ms Krestensen—We will take the detail on notice. I will just say that the work plan—or what we call the action framework—for what we and ASPAC are doing does not have a specific heading around community awareness at the moment. I suppose it is not on our agenda to take forward in that respect. Clearly issues about reducing stigma, about promoting help seeking—those kinds of issues—are right there on the agenda and it overlaps with those issues. It is an issue that we will take on notice. I think it does need clarity such as: if it is community awareness, what are the key messages? Are they messages around promoting help seeking—that it is okay to see someone if you are feeling this way? What needs to be done to support somebody? Or is there some sort of broader awareness campaign? To be quite frank, to us there has been a bit of confusion in the debate to date, and we are looking forward to having further discussions with ASPAC in the future and, in considering the results of this committee, thinking about the appropriate things that make a difference to people. I will leave it at that.

Mr Penniall—There are significant issues, and in many ways they are difficult to gauge and measure. We have a range of primary mental health programs, which we have referred to in our submission, such as the ‘at ease’ programs as well as Operation Life.

Senator MOORE—A cute title.

Mr Penniall—It was selected in consultation with the ex-service community so that they could identify it. In a sense it is one of the key activities—getting programs, getting messages out there—that our clients can relate to and understand. In fact, on those programs, with the ex-service community organisations we have been working with client groups, practitioners, clinicians and general practitioners et cetera. In rolling out some of the programs over the past few years we have contracted the Australian Centre for Posttraumatic Mental Health, the ACPMH, to try to do an evaluation of some of the programs. At one level we can say, from our awareness and early intervention programs, that we can count the number of hits on our websites and the number of pages actioned. In the last 12 months there were well over one million pages actioned. So at one level we can say that it is obviously working, but translating that into effects and a better understanding, better help-seeking behaviours, is very difficult.

A couple of years ago the ACPMH did what we call a baseline survey of 3,000 veterans. They also surveyed a number of clinicians and our own staff. They are now just about to resurvey a number of staff, clinicians and, most importantly, our clients to see whether the messages have made any impact on things like help-seeking behaviours, mental health literacy and the ability to understand—early recognition of the science of mental illness—where to go for support or assistance, and for clinicians to understand how best to treat it, or even where best to refer clients to. We will be very interested later this year to get some of the results of those evaluations, which may help us to better identify what is working and what is not—what some of the gaps are.

CHAIR—Thank you very much. I have run us a bit over time, but that was inevitable, I think. If there are any more questions that we have not covered we will put them on notice, and we will try to keep that to a minimum, I promise. Thank you very much for your time and for your submission. It is much appreciated.

Proceedings suspended from 3.55 pm to 4.08 pm

[4.08 pm]

GOLDNEY, Emeritus Professor Robert Donald, Private capacity

Evidence was taken via teleconference—

CHAIR—Welcome, Professor. Thank you for giving us your time. I understand that information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. We have your submission, thank you. I invite you to make an opening statement and then we will ask you some questions.

Prof. Goldney—Thank you for the opportunity. Just by way of background, I have been interested in the clinical management and research of suicide prevention for about 35 years. I have been involved with a couple of international groups and been president of those groups. I guess I have a reasonable perspective on it, and I hope that a little booklet that I wrote on the subject has been forwarded to you. Is that so, or not?

Senator MOORE—No, we have not got it but that is not to say that it has not arrived in the building somewhere. I see that you have mentioned it in your opening statement.

Prof. Goldney—Well, it is a relatively small booklet entitled, ‘Suicide prevention’, and I like to think that it is a reasonable synopsis of the state of knowledge at the moment. I did forward, I think, seven or eight copies with my original submission.

Senator MOORE—Was it a booklet called, *Suicide prevention: a pragmatic view of recent studies*?

Prof. Goldney—That was a journal article and the booklet considerably expanded on that, although that is a pretty reasonable synopsis of the booklet.

CHAIR—We do have that paper.

Prof. Goldney—In my covering letter I made the point that a lot of people throw their hands up and say, ‘We don’t know much about suicide’. In fact, I think we do know a lot about suicide and its prevention. One of the most important things is that it is fairly difficult to study because although it is very dramatic when it occurs it has really got what we call a low base rate, which means that it is very hard to research the effect of any intervention. As I said, although it is very dramatic when it occurs, particularly if it occurs in a family, friend or colleague, the reality is that it is very uncommon, fortunately.

So it is very difficult to research and you need quite large populations to demonstrate any effectiveness. There have been many large population studies done; not so much in Australia—we really have not had the resources to do them—but they have been done in a number of other countries. They have demonstrated that far and away the most important issue associated with suicide is mental illness. A whole range of mental disorders are associated with suicide, but that is not absolutely universal.

In some countries where there are very high suicide rates, psycho-social issues can be important, such as political oppression and that sort of thing. Also, within countries you can get variation. In Australia, for example, the Indigenous population, which obviously has its unique psycho-social stressors, has a higher suicide rate. But for the general population in Australia we are pretty well served with social security safety nets and predominantly it is mental health issues that are important for suicide and suicide prevention in Australia.

That is where I think the most important impact can be made. I have some reservations about the way in which some of the programs have gone because it seems to me that the eye has been taken off the ball. There has been focus on things like general discord, community issues, child sexual abuse—all of those issues are important in their own right, but the hope that it is going to influence the suicide rate is a bit of a pious hope. It might do something in 20 or 30 years, but it is not really going to make much of an impact.

Really, to get the best bang for the buck I think it is important to focus on really good provision of mental health services. I do not just mean psychiatry. Some people think that as a psychiatrist I am just meaning psychiatry. I mean social work, psychology and the integration of those services, and also inpatient services for people with mental disorders.

Senator MOORE—In one of your articles you say that the important thing is a combination of education and awareness plus sound treatment of existing mental health problems. Do you have any ideas about what would be the most effective way to have community education? You allude to it in your submission but it has been an ongoing issue for the committee. It would be really good if you could actually put something on record about what is an effective methodology on such an important but difficult topic to have effective education programs about.

Prof. Goldney—Yes, sure, it would be a pleasure. First of all, depression is the most important psychiatric condition/mental illness that is associated with suicide. It is very clear that organisations such as beyondblue—we always tend to use that as the prime example—have been very good at promoting information about the detection of depression and the recognition of depression in people. Other organisations, such as those under the umbrella of Patrick McGorry, have been very good for early psychosis. There has been a better recognition there. But one of the dilemmas is that, although there may be better education and better awareness, we cannot be sure that that actually translates directly into a reduction in depression, a reduction in psychosis or a reduction in suicide. Part of that is because of the difficulty in demonstrating it in the low base rate, as I said. We think that education helps, but we cannot be sure.

I think we do need to use the media, but I think we need to use it responsibly. A lot of people, as soon as the word 'media' is used, tend to say that suicide should never be reported. We tend to use the media when we want it. We have a rather double-edged view about the media. Organisations such as Lifeline or the Samaritans rely on media publicity to get it across to people to give them a call when there is something wrong. We need the media to responsibly report. Usually they tend to be responsible. Every now and again it gets too much and it becomes sensational. I think we have to live with that. Media can get across that suicide is not an appropriate action; that it is an indicator of emotional disturbance; and that there are treatments for that emotional disturbance. We need to keep hammering that message: suicide is not appropriate, it is associated with mental disorders, there are treatments—seek help. Keeping it fairly simple is the most important thing.

Senator MOORE—Have you seen examples of that where it has actually worked?

Prof. Goldney—I think the best examples are in what we refer to as the United States Air Force study. The United States Air Force study involved an enormous number of people. The United States Air Force, if you count their dependants, has several million people when you take the numbers over a 10- or 15-year period. They had a program to facilitate access to mental health professionals. They had a program which promoted what we refer to as mental health literacy to recognise problems and, as I said, to facilitate the contact with mental health professionals. They compared a period of time before and after the introduction of that and they did get a reduction of suicide. But they also got a reduction of other things, such as domestic violence, which stands to reason because mental disorders are associated with domestic violence, and in homicides.

It is the sort of thing you can do when you have the military and you can tell people what to do, so to speak. In the general population it is harder to do that, because you cannot definitely open doors in terms of facilitating treatment. In the military you can say, 'Okay soldier, you look as if you have a problem. You've got to go and see a psychologist.' You cannot do that in civilian life. We need to get across the idea: there are treatments available; see somebody about your problems.

Senator MOORE—Thank you.

Senator ADAMS—Thank you very much for your submission. We have one of your publications in our brief, which is very interesting—two actually. I think what you sent has been condensed down. I would like to discuss the older generation of farmers and their rural communities and the isolation. This is a cohort that is very hard to get to.

Prof. Goldney—Yes, it is. Also they tend to have access to firearms, which is a bad mixture, isn't it?

Senator ADAMS—I guess it is. Have you got any suggestions in that respect? Nowadays the average age of farmers is about 60 and they are so busy trying to keep going on the property that they really become very isolated and quite depressed, especially in areas where they have had drought and crops have failed and they just have not been able to borrow from the bank for their next crop.

Prof. Goldney—Yes. I wish I had a simple answer. I think the basic principles that I espoused remain important no matter what the group. Sometimes we can lose sight of the fact that there is that mental disorder. Certainly it may be contributed to by the drought or whatever, but sometimes when people are distressed by the drought or by any other external stressor, sometimes the focus gets purely on that stressor. Sure, it is important to try and do something about that stressor, but it is also important to do something about the condition that has arisen because of the stressor. Sometimes people say, 'Look, that's just a bandaid solution.' My response is, 'Well, bandaids are tremendous when you need a bandaid.' Sometimes people are reluctant to go along for help when they know what the cause may be. But it is a bit like saying, 'I know why I've got a broken leg, a truck ran over it, so therefore I am not going to seek help.' We need to get people to appreciate that something can be done. It may be a bandaid but bandaids can be good, you can get through that crisis and sooner or later the drought will break or sooner or later there will be some assistance scheme. So it is a matter of offering hope, recognising that the condition may have arisen because of the external stressor and, as I said earlier, not taking your eye off the ball of the actual condition, rather than just focusing on what the cause may be. Some people do not like that approach because, as I said, they think it is a bandaid. But bandaids can be very useful.

Senator MOORE—You speak a lot in one of your articles about data, and we know that the Bureau of Statistics has come and given evidence today. Do you have any comments you want to put on the record specifically about data collection? It seems to be something you have worked on a lot.

Prof. Goldney—I like the historical perspective and in that brief paper which I touched on about the reliability and validity of suicide statistics, they have been debated for over 200 years. I suspect they will be debated for the next 200 years. I have respect for the Bureau of Statistics, who do a difficult job well. There are all sorts of constraints about the delineation of suicide. Some of those constraints I referred to in my introduction and I am sure you have gone through them: the religious sanctions, insurance considerations, family sensitivity and all that sort of thing. So, whatever happens, some people are not going to be satisfied about it. I think the Bureau of Statistics do their best. At times they are going to—I hesitate to say make mistakes, but they will make decisions that in retrospect they will want to revise. But that is just the way of the world. I do not think we need to get too fussed about it.

CHAIR—As there are no further questions, thank you, Professor. Your submission and your comments have been very comprehensive.

Prof. Goldney—Thank you very much for the opportunity.

[4.25 pm]

BARNES, Mr Michael, Queensland State Coroner, Office of the State Coroner, Queensland

Evidence was taken via teleconference—

CHAIR—Welcome. I understand information on parliamentary privilege and the protection of witnesses and evidence has been provided to you?

Mr Barnes—Yes.

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

Mr Barnes—I have a couple of pages I jotted down roughly that I would like to refer to. I suppose it will be five or 10 minutes.

CHAIR—That is fine.

Mr Barnes—It is clear from the list of written submissions that you have received that the committee already has available to it far more expertise than I can offer and I am going to limit myself therefore to a few comments relevant to terms of reference (b), (c) and (g). Of course, I am happy to respond to any questions if you think I can help. Looking first at term of reference (b) on the accuracy of reporting, I would have thought that the need for accurate statistics on the rate of suicide is self-evident. It is obviously very difficult to design, implement or evaluate prevention strategies if you do not know the size, scope and distribution of the problem. In my view, problems do beset the currently available national statistics reported by the ABS from three different perspectives. There is the manner in which they are collated, the manner in which they are recorded and the manner in which coroners either fail to make findings or do not make them sufficiently clear. I would like to deal with those three different aspects.

Before I do, I acknowledge—and I think I have seen this in some of the submissions provided to your committee—that some experts suggest that there has always been underreporting of suicide and that, provided the trends are not obscured, that is not a problem. I defer to their expertise in that regard. I think the trouble is that there have been changes in the way suicide has been reported that mean even the trend data is not reliable. The most obvious example of that is the way the ABS changed its procedures in 2006. You will have seen in its submission that it acknowledges that from about then it abandoned examining the raw data from coroners and from the Registry of Births, Deaths and Marriages and from that time on relied instead on information uploaded from the National Coroners Information System. I can accept that as it is a central repository and, in a perfect world, that might be an appropriate way to gather the statistics. In reality NCIS, the National Coroners Information System, is a much lower priority for coroners than case managing their own workloads with a view to making findings to satisfy family members' concerns and getting deaths registered onto the local deaths registries.

Limitations of technology have been a problem. For example, in Queensland we are still required to do double entry, first onto our system and then onto NCIS to get the stuff uploaded there. I think that on occasions—and I am not sure this does not still persist—the ABS has wrongly assumed that an open file on NCIS means that the coroner has not concluded his or her investigations. In any event, as I understand it, they have not been sufficiently resourced to continue inquiring into individual matters within coroners' offices as previously occurred. Because of their changes they now rely on coders in coroners offices to upload the completed files onto NCIS. With coroners' clerks all over the country undertaking the task, it is unlikely that there will be the same consistency and accuracy as when staff reviewed coroners' files themselves. Until recently the ABS has treated open cases in NCIS as accidental deaths, even if the investigating coroner had found suicide, so long as those findings have not been entered on NCIS.

As I have already indicated, the coroner's first priority is to resolve the family's concerns and the community's concerns about the individual death and to ensure that findings are made and disseminated to those who participated in the investigation. Uploading data onto a research database such as NCIS will always be seen as a secondary function for coroners, to be attended to when time and resources allow. You can see the effect that those different approaches to the task can result in. If you look at table 2 in the ABS submission, you will see they say that as at 19 November 2009 there were 1,984 2007 Queensland cases open. I was somewhat shocked to read that. I therefore interrogated our database and was able to establish how many were open as at 19 November and found that in fact there were only 129. It is not just a slight over reporting; it is a very gross distortion. There is a similar problem with the 2008 figures shown in that same table. The ABS NCIS figures suggest there are 2,451 open files. I really think there is a problem with data entry somewhere because our system shows that there were in fact only 444 files open at that time.

My point is that the changes to the way in which the ABS has been gathering their data have resulted in obscuring even the trend in the statistics. I am pleased to note that they now intend to go back and do a revision 15 months after the close of the relevant period. I expect that will reduce but not necessarily remove the problem. When it comes down to it, it is the coroner’s role to investigate reportable deaths and make findings. It is the role of the ABS to gather data and publish statistical reports. I am fairly comfortable that Queensland coroners are discharging their role satisfactorily. If there is a problem with the data, I think we need to look to the way the ABS may have changed their procedures.

The other problem that affects the reporting system is changes to the coronial system. It is quite clear that over the last 20 years the coronial system in each of the various states has undergone quite significant changes that would impact upon the issues we are talking about. In Queensland, for example, prior to 1 December 2003, if a coroner did not convene an inquest, no findings of the circumstances or the manner of death were made. The medical cause of death was simply entered onto the register kept by the Registry of Births, Deaths and Marriages. Similar changes have occurred in some of the other jurisdictions around the country, but there are still some states—South Australia and New South Wales—in which there is no mandated requirement to make a narrative or descriptive finding of the circumstances of death if an inquest is not held. These changes in the way coroners’ findings are recorded and collated also mean the assertion that, even if the totals are wrong, the trends in the statistics can be relied upon, is questionable in my view.

The third cluster of things that impact upon the accuracy of suicide stats in my view are the ways that coroners respond, particularly to apparent suicides. I think I am on fairly strong grounds to say that traditionally coroners have been reluctant to make findings of suicide because of the religious, legal and social ramifications of those findings. While the body of a person who commits suicide is no longer dragged behind a horse by one leg at midnight and impaled with a wooden stake at the crossroads before being buried in unconsecrated ground, as was the case only a couple of hundred years ago, certain sensitivities still undoubtedly remain. In England and in Australia there have been numerous appeals against suicide findings by family members seeking to have an open finding or a finding of misadventure substituted. Coroners naturally want to avoid such challenges and so I think are more hesitant to find suicide than say accident, even if the evidence is sufficient.

Although we have a statutory basis, we come from an English tradition and certainly suicide findings in that country have and continue to be made to the criminal standard. I assume this is a hangover from when suicide was a crime. English coroners have sought to avoid the harshness a suicide finding might be thought to entail by various means. I do not know whether you saw the newspaper reports of the coroner’s finding in relation to the death of the famous clothes designer Alexander McQueen that were published last month. In the time-honoured fashion, a London coroner found that Mr McQueen killed himself while the balance of his mind was disturbed. That is a common wonderfully circular artifice that English coroners have used for a long time. It goes like this: they say that no-one would kill themselves unless their mind was disturbed or they were suffering from a psychotic episode; therefore, if someone kills themselves, they must have been suffering from a disturbed mind and could not have formed the requisite intention to take their own life. In that way you almost guarantee that you will never have a suicide finding.

I think there is a tendency to take that same approach in Australia. You say that a person is suffering a psychotic episode and, therefore, they really did not know what they were doing on occasions when I think that is not quite supported by the evidence.

Unlike in England, in Australia coroners only need to be satisfied to the civil standard of proof—the balance of probabilities—to make any finding. You have probably heard the Briginshaw principle referred to. It was named after a High Court case. The old matrimonial causes jurisdiction was to the effect that, before making a finding as serious and as improbable as a married woman committing adultery, a court would need to find overwhelmingly compelling evidence. That sort of approach has been used in relation to suicide to I think unnecessarily inflate the standard of proof needed to make the finding.

I accept that for coroners finding an intangible—the intention to self-destruct absent a definitive statement from the deceased in a suicide note—can be difficult. It combines with a desire to perhaps spare the bereaved further suffering and, as I mentioned before, risk a higher court challenge. As a result it deters coroners from making findings of suicide as freely as they make alternative findings with no more evidence. To get a fair picture of that hesitancy you only need to look at what happens in the magistrates courts operating in the criminal jurisdiction every day of the week. They find, despite sworn evidence to the contrary, that a person had a specific intention—namely, according to law, what is the natural and probable consequence of their act that is found to be the intention of people charged with criminal offences. For some reason when those same magistrates put on their coroner's hats they suddenly become more timid and require what they refer to as positive evidence or proof of the intention.

I think there are a number of solutions that we could apply to that problem, which I think is widespread. Talking with my colleagues around the country I think it is becoming increasingly recognised as a problem. I readily acknowledge that it has had a kindly disposition of the coroners as its main motivating experience, their desire to protect the family from the added distress that a finding of suicide might bring. In my view because of the damage it does to public policy and the attempts to redress the problem, it is a misguided approach in any event.

But, as I say, I think there are a number of solutions. State or chief coroners have the capacity in all states to give directions to local coroners. In my own case I have given a degree of fairly structured guidance and I have taken the further step of reviewing all possible suicide findings to satisfy myself that they have been appropriately coded even if the local coroner has been a little less than explicit in his or her findings in relation to the intention of the deceased person.

The other obvious solution is to expand the Queensland Suicide Register. I saw on your program that you were hearing from people from AISRAP today—

CHAIR—Unfortunately, we did not hear from them this morning as the witness is sick.

Mr Barnes—That is terribly sad because they are certainly an expert body. They are connected with Griffith University in Brisbane and are a World Health Organisation accredited research facility.

CHAIR—I beg your pardon. I was ahead of myself. They were here.

Mr Barnes—So you have heard from Professor Diego De Leo and his colleagues?

CHAIR—Yes; they were here.

Mr Barnes—Wonderful.

CHAIR—Sorry, I was locked into thinking about the committee that is dealing with—

Mr Barnes—The National Committee for Standardised Reporting of Suicide.

CHAIR—We were supposed to hear from them but they were sick.

Mr Barnes—I see. I am on that committee, so I will pretend to speak for them as well. Professor De Leo and his colleagues operate AISRAP. One of the functions they very effectively discharge is the Queensland Suicide Register. We have mechanisms in place to identify each possible suicide. At the time the police who provide us with information about the death are gathering information from family members they seek the consent of those family members to provide their contact details to AISRAP. Surprisingly perhaps, between 80 and 90 per cent of the families agree to that happening.

The research that AISRAP can do as a result means that we think almost all suicides are being accurately identified as they occur in Queensland. There are a number of exceptions that I might mention a bit later around certain types of deaths but the most frequent and common forms of suicide—hanging, shooting, drug toxicity, fall from heights and the like—are easily identified as potential suicides and AISRAP filters them in a way that is much more scientific than the legal construct that sometimes hinders coroners making similar findings.

There is no reason that AISRAP could not apply that same model to all of the suspected or potential suicide deaths from around the country. It would simply require coroner's offices in each of the states and territories to enter into similar arrangements with that institute. I think the problem would largely be addressed. That is all I want to say about the under-reporting of the suicide rates. I now want to talk a little about the role and effectiveness of the other agencies.

Before I make comments that might be construed as critical, I want to say that coroners readily acknowledge that they only see the failed attempts at suicide prevention. We know there are many more thousands, perhaps hundreds of thousands, of people who do benefit from the therapy they receive and obviously then do not become coroner's cases. We also acknowledge that, despite the very large numbers of suicides that come before coroners, it is still relatively rare if you look at the number of people potentially at risk of dying in that manner. We are conscious of the need to try to control for hindsight bias and keep a perspective around the number of cases that we see.

Having said that, it is incontrovertible that suicide is by far the biggest category of unnatural deaths that comes before coroners. In Queensland, for example, we get about 3,700 deaths reported to my office each year. A bit more than half of those are natural causes and then by far the next biggest category is suicides—around 600 in Queensland. The road toll is a terrible thing that we are all concerned about, but it by comparison accounts for about 300 deaths in the same geographic area. Homicide on the other hand accounts for 60 to 80 deaths each year. I think the scope of the problem needs to be acknowledged and properly gauged, as we have been talking about already this morning.

So recognising that we only see the unsuccessful attempts to deflect people from self-destruction and recognising that in hindsight it is easy to find fault with the way individuals have been dealt with when in fact they are a small number of a much bigger pool that interact with the agencies, there are still concerns from our perspective. Too often we see detailed reports about police intervening in suicide attempts and taking the attempter to an emergency department only to see the person released an hour later and make another attempt at or even complete suicide that same night. I am sure you can understand how distressing it must be for families to hear when they are told that their loved one was taken to a hospital and discharged within hours before they killed themselves.

Equally distressing, it is not unique for us to hear about patients who are discharged from an inpatient position in a mental health ward who leave the hospital and go straight to the nearest train station and jump in front of a train. Again, it is difficult to be unduly critical if you do not have expert knowledge about how those decisions are made, but they surely call into question the efficacy of the decision making involved.

It seems to me, without purporting to have undertaken a scientific analysis but more anecdotally from the number of cases we deal with, that there are problems that might be able to be addressed to reduce those sorts of outcomes. One is more training for police on how to respond to people in crisis and how to interact with people suffering from psychotic episodes. Too frequently they seem to rapidly degenerate into a fairly violent stand-off that results in police or the civilian being severely injured, sometimes shot, and then ending up in a watch-house—if they are not killed, obviously—rather than in a place where they might get health care.

I think we could also do more to ensure that hospital emergency departments have access to trained mental health staff at all times. Too often we see suicide attempters being discharged from an emergency department without having a detailed mental health assessment undertaken even by psychiatric registrar, let alone a psychiatrist. I recognise the resource limitations that apply in the public health system, but it is something that I think has to be acknowledged as a contributor to these problems.

Another problem we are frequently told about is the refusal of some mental health practitioners to involve families in treatment decisions for patients. I acknowledge there is a balance between a patient’s right to privacy and the welfare of the patient that can be advance by involving close family members in their care. It is a difficult balancing act to undertake. I recognise that just because someone is suffering from mental illness does not mean that their right to doctor-patient confidentiality is lost. On the other hand, I frequently see circumstances where families have, over many years, dealt with extremely challenging problems presented by ongoing mental health suffering among family members and who tell me with conviction that the family member—their child, usually—was very happy for information to be provided to the parent when the child was well. When the child is in a florid state, and often that involves paranoia, they become much more secretive. I have never quite understood why there cannot be a greater use of advanced health directives or other standing powers of attorney that authorise this distribution. Queensland legislation has been enacted to authorise the release of confidential information that would normally be kept private if it is in the patient’s best interest, but the repeated claims of families that they are locked out is something that I have heard so often that I have to accept it as valid.

Equally, as a result of your work on this committee I am sure you have become aware, if you were not already aware, of the shift towards the least intrusive or least invasive principle in providing treatment—to everyone, but particularly to sufferers of mental health problems. It seems to me that in many cases that has gone so far that involuntary treatment is not provided when it is needed. I am not sure that my rights are being respected if I do not get treatment that I am too sick to know I need. If I am unconscious on the street, an ambulance officer is quite entitled to stick needles in me and pump drugs into me. It seems that if I am psychotic it is much more difficult for me to get help if I am discouraging the possible providers of that help. It seems to me that we need a more robust approach, or at least a review of our reluctance to invoke involuntary treatment orders, the monitoring of medication compliance and the like.

I am aware of course of the very significant and respected body of academic opinion about the benefits of a population or public health approach being more appropriate than seeking to review individual cases and risk manage those cases. I understand the idea is that if you can improve the general mental health of a population then fewer people will fall below the crisis line. While that may be so, it does not help the families of those who have died or those who fear that their loved ones will be next. Obviously they are the people that I deal with most often.

I and my colleagues readily accept the difficulty of distinguishing between people at chronic risk and people at acute risk of suicide. I understand we cannot treat all those at chronic risk in the way that we need to treat those at acute risk. There seems to be an abundance of evidence that there are known and identifiable risk factors that assist in making that categorisation. Too often coroners see a risk assessment undertaken in a very non-systematic way. I understand the dispute about the efficacy of risk assessment instruments and how an untrained person can have difficulty applying them, but to an interested observer like myself it would seem more beneficial having some tested and reliable assessment instruments rather than imagining that a holistic qualitative assessment can be undertaken by an intern or an emergency registrar who has little or no training in mental health.

The last point I want to mention about the response of agencies concerns prison cells. Certainly in Queensland and I know in some other states, hanging points and resulting suicide by hanging continue to be a blight on correctional services. It is certainly the case in Queensland that governments can find billions of dollars to build new superprisons but apparently cannot find the much smaller amounts needed to make safe the cells currently in use. In just the first four months of this year three prisoners have hanged themselves in Queensland jails. The last topic I want to say a few things about is term of reference (g), about research.

CHAIR—Mr Barnes, we need to wrap it up quickly because we are on a fairly tight time line.

Mr Barnes—I understand. I will spend one minute on research. We have enthusiastically participated in research projects undertaken by AISRAP and I gratefully acknowledge the willingness of the Queensland Police Service to do the same. It is disappointing that the Family Court, which was approached repeatedly to participate in research into the deaths of usually male litigants in that court, refused and other government departments in Queensland also declined. Anything that this committee could do to encourage government departments to participate in research would, in my view, be useful. That is all I have.

Senator MOORE—Mr Barnes, you have covered just about everything I wanted you to say and as a Queenslander I am very pleased.

CHAIR—She is showing bias.

Senator MOORE—It is really important for us to know all of that stuff, particularly on prisons. One of the things we have talked about—and I am interested to get your view as a Queensland coroner—is the lack of consistency around the country with methodology. This is not so much about the resourcing of coroners areas because you are united on the fact that you are all under resourced. Rather it is about the forms that are used by the police to give you the information, a topic talked about by SPA, and the data-reporting system. One of the comments in your evidence was that the one you are using in Queensland seems to cover things well and is a useful tool. What is the prospect of getting an agreement across the jurisdictions to get some consistency?

Mr Barnes—I think you are right that it is a problem. I am really at a loss to know why the other states have not adopted a more comprehensive initial information-gathering form. We used to refer to it as the 'Victorian form' because the Victorian police designed it first, but they have never adopted it. Apparently they are again looking at it now. New South Wales is looking at it but has not used it, Western Australia has a similar form and South Australia does not. So the initial intake varies and in some cases is quite sparse.

We had the same problem in Queensland until the 2003 act. The most sparse report I saw from a police officer gave the name, date of death and then: 'He died yesterday.' I had to make decisions about the investigation. That is a problem and the follow-up, how that information is then put to good use, is something that will only happen if we get some consistency in the legislation. As I mentioned, in South Australia and in New South Wales there is no need to make findings if you do not have an inquest. Indeed I think the South Australian coroner believes he does not even have power to make a narrative finding without an inquest. New South Wales gets around it by a state coroner's direction that requires them to give reasons about why they are dispensing with an inquest. That contains some description of the manner or circumstances of the death. One of the joys of federalism is the inconsistency that, in this case, I think causes problems.

Senator MOORE—Evidence we got from the group Suicide Prevention Australia, which looks at statistics, was that a number of these calls for consistency have been put forward for consideration. I am wondering, when you coroners get together, how much consideration you give it.

Mr Barnes—It is discussed at most of our annual meetings and it surprises me that there is some resistance. It tends to be around: ‘How are we going to get the police to do this? They won’t want to gather all this data. We have not got a case management system to enable us to upload this data.’ It is that sort of objection. There is no objection in principle. Whenever we have discussions at presentations about the seriousness of the underreporting of suicide, everyone nods their head and says, ‘Yes, we must do something about it.’ Unfortunately, it is an ongoing problem, despite that.

Senator MOORE—Do you need your attorneys-general to agree and put it forward?

Mr Barnes—I think SCAG could be a good forum to drive that consistency.

Senator ADAMS—I just wondered if you have been listening to the questions I have been asking all day, because you have covered just about everything. I did speak to the department about collation of the data and the coding model that the ABS were using. What worried me was that they were going completely on the National Coronial Information System and what happened with the initial coding, probably even before it got to you for sign-off. It worried me that there is a gap in the middle. Has there been any audit of that particular area?

Mr Barnes—I know that NCIS does try and audit its data periodically. I think the greater problem is that local coroners are not necessarily seeing NCIS as a priority; they are managing their problems more in-house. I think that is probably where the problem is occurring. Again, as the previous questioning indicated, I think it is a role for state and territory coroners to take greater leadership in. You know that, generally speaking, all magistrates throughout the country are also coroners. Not all of them are enthusiastic about what they would see as interference. Mine have accepted my role in that area, and now I undertake that auditing. Professor De Leo and his colleagues have a much more scientific way of examining each of the potential cases—I hope you heard this today from them—and of producing data that is probably independent of the coroners. Coroners operate within a legal framework that may be satisfactory for a legal system or situation, but suicide is a public health issue and I think a health based approach is probably better. I cannot see why the approach they use with the Queensland Suicide Register that gets data from coroners could not operate nationally.

CHAIR—You gave such comprehensive answers and opening statement that you have basically answered all my questions, except one on this issue around a common approach. You went through the different states with your understanding of who uses what. I asked the ABS this morning about the need for a national standardised approach on data reporting, findings et cetera. Would that be the best way to go?

Mr Barnes—I think it certainly would approve things. We need greater consistency and greater focus on why we are making the findings. There is a bit of a disjuncture between the collation and aggregation of data for public policy issues and the findings that coroners make in particular cases, usually responding to the prompts or complaints from family members or others, and that tends to skew things a bit. You get bogged down in details on a particular case and then, by the time you have resolved those concerns, making sure they are coded and uploaded onto a national database to be looked at for research purposes seems a very remote and almost irrelevant activity. Someone needs to take charge of taking information out of coroners’ offices and getting it into a form the ABS can publish it in. Frankly, I would have thought that was the ABS’s role, and certainly that is what they used to do—they used to come into the office and spend a week or two reviewing the paperwork. I do not know if it is a reduction in their resources that prevents them from doing that, but I think we had a better system when that was happening. It is the change in that system that has the potential to skew even the trend analysis. If we do not acknowledge there has been a very significant change in the way the data is collected, I do not think we can be honest about whether we can see changes in trends.

CHAIR—When we were in South Australia, it was reported that the coroner’s office was pointing out that it cannot report a finding on intent unless there has been an inquest, and you touched on that in your evidence. It seems to me that it would be better to have a common approach. As you said, different states do different things. Is it better to have a common approach—and I know that might be hard—across the whole of Australia?

Mr Barnes—I would love a federal coroner’s jurisdiction, and we all just take model acts. I cannot understand why, if I am with my Western Australian friend and we get washed off a beach in Bali and neither of us is found again, the Western Australian coroner cannot find me dead unless he is satisfied beyond a reasonable doubt, whereas a Queensland coroner only needs to find on the balance of probabilities. It is crazy that there are significant differences between the jurisdictions. But I do not imagine that is ever going to happen. The more similar the systems are made the better it would be for people wanting to get national data, of course.

CHAIR—Thank you very much. Your time is very much appreciated. It has been extremely useful for us.

Mr Barnes—Thank you and good luck with your very important task.

Committee adjourned at 5.01 pm