



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

**HOUSE OF
REPRESENTATIVES**

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Youth suicide

TUESDAY, 20 APRIL 2010

MELBOURNE

BY AUTHORITY OF THE HOUSE OF REPRESENTATIVES

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HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON HEALTH AND AGEING

Tuesday, 20 April 2010

Members: Mr Georganas (*Chair*), Mr Irons (*Deputy Chair*), Mrs Bronwyn Bishop, Mrs Gash, Ms Hall, Mrs Irwin, Ms King, Mr Neumann, Ms Rishworth and Dr Southcott

Members in attendance: Mr Georganas, Ms Hall, Ms Rishworth, Dr Southcott

Terms of reference for the inquiry:

To inquire into and report on:

The need for and success of early intervention programs aimed at preventing youth suicide.

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Committee met at 1.02 pm

CHAIR—Good afternoon. Thank you for attending today. I would like to make a very quick statement. I declare open the public forum on early intervention programs and preventing youth suicide. According to the Inspire Foundation, suicide is one of the leading causes of death among Australians aged 15 to 24, alongside road and traffic accidents. In addition, according to Orygen Youth Health, one in four young people will experience a mental health condition at any time in the next 12 months. These are staggering statistics. Therefore the committee has decided to convene this roundtable hearing to better understand early intervention programs aimed at preventing youth suicide.

The committee hopes that this forum will discuss what works and why, in the area of suicide prevention, so that we can take these lessons forward into future suicide prevention programs. I would like to take this opportunity to thank each and every one of you here for making time to speak with us here today. Your evidence will be used in the preparation of a report which will make recommendations to the Minister for Health and Ageing. Although the committee does not require you to speak under oath you should understand that these hearings are formal proceedings of the Commonwealth parliament. Giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament.

[1.05 pm]

BALDWIN, Miss Rachel Louise, Youth Advocate, MindSavers

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FINN, Ms Judy, Program Director, Public Health, beyondblue

GRAETZ, Dr Brian, Program Director, Education and Early Childhood, beyondblue

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

CHAIR—I will just quickly explain the session guidelines. We will begin the interactive roundtable sessions. However, before we commence I would like to remind the participants of the format that these sessions will take. At the start of each session I will announce the theme and provide each organisation with the option to speak to the theme for up to three minutes. If you go over the three minutes Penny will ring a bell or do something, which means that your time is up. Penny will indicate when you have 30 seconds remaining. Participants should note that they are not obliged to make a statement on a particular theme so, if you do not wish to make a statement, just indicate and we will go to the next speaker. So that we can ensure everybody has an equal opportunity to speak we will maximise the time for questions and discussions and we will try to adhere to the three-minute limit.

Following the introductory statements, members of the committee will have the opportunity to ask questions. Following questions I will then invite members and participants to engage in an open, general discussion relevant to that particular theme. The general discussion will be the focal point of each session. It will allow us to clarify issues and will provide the setting for participants to exchange ideas.

Before we start, the committee needs to table some submissions. Is it the wish of the committee that submissions Nos 1 to 4 be accepted as evidence in the inquiry into youth suicide prevention programs and that they be authorised for publication? There being no objection, it is so ordered. These particular submissions are to be registered: University of Queensland, Lifeline Australia, the Royal Australian and New Zealand College of Psychiatrists, and the Inspire Foundation.

The first session is: what are the facts? This session aims to understand the current rates of youth suicide in Australia, as well as the future trends. Perhaps if we start with Deborah and then we will work our way around the table with three-minute statements.

Prof. Milroy—I will make a statement to get the ball rolling. I just wanted to make some comments about the issue of Indigenous statistics and the Indigenous population. First of all, the statistics are really quite inaccurate. There are clearly issues around some of the underreporting that goes on. I think we are all already aware of that. The other issue is about the blanket approach. Clearly, for some Indigenous communities suicide occurs within a very discrete community setting, which means that the suicide rates for that particular community can be extremely high, as opposed to the national averages, which tend to underestimate the needs of a particular community. So a blanket approach to suicide prevention is either going to not work for communities that are doing extremely well, because they do not need it, or it is going to fall short of the mark for communities where the rates are extremely high.

The other issue I wanted to raise about the Indigenous approach is that cultural approaches are often ignored. There are ongoing problems with the access to, and appropriateness of, services. The other main point I want to make about Indigenous communities is that, because we have such an altered population structure, with few elders, a smaller number of adults and a massive number of children—a very young population—the approach needs to be entirely different. It has to be developmental and generational if it is going to be sustainable over time.

As a child psychiatrist I just want to make one other point about children. That is that from my clinical experience, the number of children presenting with self-harm is increasing and it is starting at a younger age. We now see children who are practicing suicide at the age of six—playing suicide games—and we have already seen children between the age of eight and 10 with quite significant self-harm. If we only focus at the tipping point in youth we are really missing proper intervention in children.

I also want to clarify one point around the difference between early intervention and intervention. We talk about early intervention in children but some of these children actually need appropriate, comprehensive intervention services. It is not at the soft end of the spectrum. Thank you.

CHAIR—Thank you.

Ms Blanchard—I just want to make a brief statement with regard to young men and their mental health and wellbeing and risk of suicide. Across the OECD we know that the rates of suicide are highest for male young people aged 15 to 19, and Australia has the ninth highest rate of suicide in the OECD for young men.

Male youth suicide is clearly a major problem in Australia and I would like to draw your attention to some research that is being conducted by the Inspire Foundation and funded through the Australian Research Council. This particular research is being conducted in conjunction with the Brain and Mind Research Institute at the University of Sydney. It is based on 17 focus groups conducted with young men around Australia. So this really brings young men's voices to the table.

Young men have much-reduced levels of help-seeking. Only 13.2 per cent of young men requiring help for mental health difficulties seek help. Young men reported in this study that the major barriers to help-seeking included: not knowing how to talk about their problems, not liking talking about mental health and wellbeing, considering mental health and mental illness to be a weakness, and feeling that emotional issues are quite a feminised concept and really at odds with their sense of masculinity. Professional services for them were simply not on the radar and they felt that depression was only legitimate under extreme circumstances—situations like a family member dying or a break-up with a long-term girlfriend.

It is really clear from this preliminary research that much needs to be done to address the problem of poor mental health amongst young men, and its contribution to suicide. This information is going to be available in a report towards the end of 2010. One of the issues that were signalled in the report was the opportunity to use information and communication technology. I would be happy to speak further to that when we start to talk about solutions.

CHAIR—Thank you very much.

Ms Robinson—I suppose I would just like to draw the committee's attention to the other couple of key high-risk groups for suicide amongst young people—people with mental health problems, whether it is a diagnosable mental disorder, psychological distress or a time of crisis—and people with previous suicide attempts and deliberate self-harm.

There has clearly been a lot of debate recently over the accuracy of data and recording of data around suicides amongst the general population, but what we do not seem to be talking about at all is how well we are recording suicides that occur under psychiatric services or suicides that occur amongst people who have previously engaged in self-harm or suicide attempts. Given that we know that those groups are at significantly higher risks for suicide I think one of the things we should be talking about are ways that we could be examining or robustly recording suicides that occur in those groups. There are precedents set in other countries that have been able to do that reliably and robustly. That has enabled those countries to really target preventative activity quite specifically. I think we could be learning from some of those examples.

Dr Mathews—I am in agreement with everything that has been said. The only thing I would like to add is that it is quite clear that suicide rates have not declined, and recent publications that have indicated that Australian suicide rates have declined have been shown to be problematic.

Dr Watson—We would like to thank the standing committee for conducting this inquiry and considering the submission of the Royal Australian and New Zealand College of Psychiatrists. In doing so, could I acknowledge the impact of suicide on families, friends, workplaces and communities throughout Australia. In respect to suicide prevention, the college believes all Australians need prevention and early intervention programs. Australia needs a suicide and self-

harm reporting system that works. We need to improve mental health literacy because that is necessary to reduce the stigma associated with mental illness and suicide. Prevention programs must include both universal and indicated strategies to target both the general population and those with early manifestations of problems. In particular the introduction and maintenance of rigorously evaluated prevention and early intervention programs across all age groups is essential. For youth, this requires a particular focus on depression, suicide and self-harm.

A narrow focus on terms such as 'early intervention' is insufficient. There is a need for improved services for those at risk. Post-discharge support for suicide attempt survivors is essential. There is also a need for improved detection and management of youth depression. There must be appropriate and easy to access services for those with social disadvantage and high suicide risk. A good measure of how well we provide services to those who are poor, male, Indigenous or generally disengaged from society.

An improved reporting system is required to ensure consistent, accurate, reliable and timely reporting. This requires increased resources and collaboration between relevant agencies. Improved data is essential to support further research, evaluation and analysis of suicide prevention strategies. Together with increased resources for suicide research and treatment program evaluation, suicide can be analysed and preventable deaths avoided through improved strategies.

The research funding gap is stark. Despite being comparable in terms of death rates, funding allocated to breast cancer is significantly higher than that allocated to suicide prevention research. Until this funding is increased, we cannot argue that we are effectively tackling this problem. Improving the level of mental health literacy among the general population, particularly parents, peers, teachers and community leaders, is crucial to identify early risk factors for suicide. Reducing stigma is an essential part of encouraging help-seeking and appropriate referral. Even among young people with the most severe mental health problems only half receive professional help. Parents often do not know where to go to get help or believe that they can manage on their own. This is a particular issue for communities and families where help-seeking is not part of the culture. Stigma prevents people from seeking help.

Improving awareness of risk factors among parents is key to ensuring that early indicators of mental health problems among their children are detected. The Royal Australian and New Zealand College of Psychiatrists is well placed to comment on this area of preventable deaths within the Australian community. We are the peak representative body for over 3,000 psychiatrists in Australia and New Zealand. We have the privilege and responsibility of training and accrediting high-quality psychiatry graduates and continue to serve our community. Psychiatrists are medically trained specialists in mental health. Every day psychiatrists treat people to reduce the risk of suicide. This work occurs across the life span from children to older people and covers a broad spectrum of mental disorders.

Suicide risk factors are complex and a range of health professionals, including our colleagues represented at this table, have an important role to play in prevention. Psychiatrists offer unique insight into the biological, psychological and social aspects of individual family and community experience of mental health problems. In regard to suicide, this involves the assessment of complex cases and identification of risk factors and treatment options.

Psychologists are calling for better services for those at risk, improvements to the system of national suicide reporting, increased research and evaluation, more suicide-prevention public awareness campaigns and training for people who come into contact with those most at risk of death by suicide. In closing, I would like to repeat on behalf of the college my appreciation for this critically important issue not just for the Australian government but for all Australians.

CHAIR—My question is to Helen Milroy. I was very alarmed to hear about young children playing suicide games. Would you like to elaborate a little more on what that is, what they do and why they get into it?

Prof. Milroy—It is a very complex issue. Clearly, these children come from families where there are a number of different factors that operate such as violence, personal traumas, separation, deaths and all of those sorts of things. These are families where there is a complex set of factors. From my clinical experience—working with some of the Indigenous communities and also working across the board with children from non-Indigenous families—it seems to me that these sorts of things are becoming more common. It may also be the influence of other things in the community such as the violence in video games and other things like that, which perhaps desensitise children to some of these sorts of things.

One example I can give you is a little boy who told me that he had been practising suicide since the age of six. He, his brothers and his cousins used to string themselves up on the clothesline and swing the clothesline around, pretending to hang themselves. They had witnessed hangings within their community. They had been playing that since the age of six, so by the time he was 11 he hanged himself at school. That was when he came into services. I think that he was missed for at least five years of the progression of his level of distress, to the point that it was an attempt at 11 that brought him into contact with services. Similarly, other children have played out things in preschool, for example, in an environment where they are playing with toys. No-one is watching that and picking it up. Other children I have seen have started self-harming with things like pencil sharpeners, paperclips and things like that, scratching their necks, arms and whatever from about the age of eight or 10. If they are already doing that at that age, it is not a big leap by the time they are 14 or 15 to make a more serious attempt.

Ms HALL—I have two questions. Helen, when you spoke you talked about Indigenous communities, the blanket approach to collecting statistics on Indigenous deaths caused by suicide and how it needs to be looked at on a community-by-community basis. I am sure you have done some research into that area and I wonder if when you have looked at communities you have found that there are certain incidents or catalysts that cause those communities to have higher suicide rate? Are there actions that can turn that around?

Prof. Milroy—I think the best interest for looking at discrete communities comes from Canada. There were two researchers, Chandler and Lalonde, who looked at this. They looked at First Nations communities where the suicide rates varied from less than the rest of the Canadian population to rates something like 200 times the non-indigenous rate—from very low to extreme. When they looked at the factors in those communities that safeguarded or lowered the rate for youth suicide—youth suicide was seen as the tipping point to measure how the community was going—the factors were around self-determination. It was those communities that had a degree of control over their communities and how services were delivered to their communities and that had a lot of say in what happened, including in things like control over

land and resources, that had lower rates of suicide than the rest of the Canadian population. The more of those controls or measures they had in place, the lower the rates. It was a cumulative effect.

Those communities that had very little control over what they did and how things were managed within their communities had the more extreme rates. Although that is not directly comparable to the Australian context, there has been some literature about some discrete communities that were not naturally occurring. These were communities that were brought together either through missions or through other sorts of dispossession experiences, so they were kind of put-together, made-up communities. They seemed to be the communities that struggle most today compared to those communities that are able to remain on their natural homelands.

Ms HALL—My next question is to anyone who would like to come in on it. We have talked about how it has been identified that young Aboriginal and Torres Strait Islander men are most likely to commit suicide, but there is one group that has not been touched on at all by any of the presentations. That is young women. I have to focus on this because there have been a couple of young women in my electorate who have been affected by this. That is young women suffering from postnatal depression. I want to look at whether any of you are doing work in that area, because it does affect young women and youth.

Miss Baldwin—I think depression is being touched on with beyondblue. One of my family members is bipolar. I think schizophrenia and bipolar disorder need to be touched on more. Depression is a lot broader now, but even those two need to be touched on more in addition to depression.

Ms HALL—So it is something more than just the standard approach?

Miss Baldwin—Yes, there is a lot more there that needs to be touched on. Depression is a good start, but yes.

Ms Finn—In relation to your comment about the concerns of postnatal depression, the work of beyondblue across the board has a focus on depression and anxiety disorders. Postnatal depression is a very important part of our work. I would like to add for the purposes of context that depression and anxiety feed into this discussion of suicide, as we recognise that major depression is a significant risk factor for suicide. We see the work that beyondblue does to raise awareness, to try to change social attitudes, to facilitate destigmatisation and to encourage help seeking as some of the things that may work to prevent suicide further down the track. Postnatal depression in particular is a thing that is more commonly experienced than perhaps has been evident in previous years. There is now a comprehensive body of work aimed at raising awareness—in particular amongst women, their partners and their health professionals—of the signs, symptoms and where to get help. There is significant work around routine screening and with Commonwealth funding we are in the process of implementing a national screening program as well as some training and awareness raising for health professionals so they will be better at pickup and better at appropriately referring women on. That is not to say that that is the end of the job; it just identifies what is happening.

Ms HALL—My cases were very recent. Two young women committed suicide.

Mr Tanti—My colleagues from the college might be best placed to make this comment. From a structural perspective, within hospitals there is generally no link between what occurs in obstetrics and what occurs in psychiatry. It is more a consultation/liaison role. Given the duration of care for a birth—it is generally up to seven days—there is limited opportunity for a psychiatric intervention and often the referral is not made. From my perspective, it seems that it is much more a structural problem. In my experience of having children—of course I did not bear my own children; I was merely part of the process!—there was no discussion in maternal and child health of postnatal depression, but in some instances people were presenting with these problems. So I see it as more a structural issue. Certainly the expertise is there—beyondblue has done some terrific work in this space, as have others—but things do not link up within the sector.

Miss Baldwin—I definitely agree. There was a family member who had a baby and was told she had to get off her medication. For nine months she struggled because she did not have any of her medication, and then when she had a baby she started going downhill. It definitely needs both parties to intervene before things happen.

Dr Watson—We have an active group of psychiatrists who have formed a special interest group. They are not just prominent in Australia but also prominent researchers who are respected across the world. Many of those people work in hospitals and provide the sorts of services that might generally be lacking, but there are specific places of expertise. One of the areas in our submission that this picks up is the idea that there are gatekeeper staff. That is a phrase that I am not necessarily enamoured with, but it makes the point that there are other people who need to be literate and picking up cases. The places and hospitals where that works best are where midwives doing antenatal clinics are actively involved in the screening process. A couple of our fellows have been very active and have published in that area—Professor Bryanne Barnett in south-western Sydney and Dr Belinda Edwards in the northern suburbs of Adelaide based at the Lyell McEwin. Those two areas of marked urban disadvantage have been able to develop programs where there is comprehensive screening by those gate-keeping staff.

I would just like to pick up the points that others are making. We have already talked about the fact that men and their help-seeking behaviour and mental health literacy creates a special problem for women who are pregnant or postpartum as the majority of them have men involved in their life at some level. So increasing that background literacy that there are things that can be done, it is not stigmatised to say that there are problems and to have a higher expectation of services, are really important parts of the general population work that goes into those relatively uncommon but devastating events, not just for families but for the broader communities.

Prof. Milroy—If I could just make one more comment about young women and that adolescent group. I think there is perhaps still a little bit of an attitude or a stigma about teenage girls taking overdoses and things like that and the treatment they get within services as being a nuisance rather than being in need of proper services. I think that is still an ongoing issue.

Dr Mathews—I will make one more comment about postnatal depression. I think we are focused a lot on hospital and postnatal depression does not always present in the first week, so we really need to acknowledge that more work has to be done in the community, particularly with GPs, maternal healthcare nurses and people who are in contact with these young women. They need to be trained to be asking the right questions.

Dr Selway—We talked about the groups that are missing around the table and I would like to add the gay, lesbian and transgender group, which has a high incidence of psychological distress. So, together with young men and Aboriginal communities, we also need to address that sector of the community as high risk.

Dr SOUTHCOTT—I would like to ask the round table a question about the media reporting of suicide. Young people, especially vulnerable people, can be influenced by the media reporting. There have been a number of higher profile suicides recently. I think some of the reporting has been very good. I think some of it has not. I would just be interested in your views on that. Is this something important? Is it important that journalists do follow their own codes in terms of the reporting to avoid incidences of copycat suicides or actually affecting people who are already quite vulnerable?

Ms Finn—I come from a public health background and so, when I realised I was attending this, I felt the need to do some reading. One of the incredibly helpful resources I came across was a resource called Mindframe, which has been designed for people working in the media and deals with how to treat the issues of suicide in their coverage. If I may, I would like to read a quote:

People in despair may be influenced by media reports or other public discussion where they identify with the person in the report, or where suicide is glamorised, romanticised or portrayed as an ‘acceptable’ course of action.

This is supported by evidence gathered both here and internationally. So, whilst we earlier talked about campaigns around suicide and more discussion along the lines of destigmatisation and encouraging help seeking, I think at the same time we need to be very mindful that, unless handled very carefully, there is a potential downside to this.

Dr Watson—The evidence is in that sensationalist, irresponsible reporting in the media is dangerous for all of the reasons that you have mentioned. The other problem with it is that we miss an opportunity for positive, helpful reporting. Again the evidence is that, if you deal with the subject sensitively—if you reinforce the idea that, if people have problems, they need to seek help and help is readily available and it is usually very good and of a high quality—then that is terrific. Australian of the Year, Professor McGorry, recently on an ABC program was talking very sensitively with a roundtable, including people who lost loved ones by suicide, and emphasised the point that by doing that, by bringing it out into the open and talking about it, we destigmatise suicide. The early research evidence on that is that we actually lower the rates.

The media have an opportunity to helpfully contribute. By following their code of conduct and embracing what they already know is very important. We and other groups encourage members of parliament to be quite outspoken when media do take that sensationalist view. Unfortunately, there is always the risk that those parts of the media that enter into that sensational view will then sensationalise what those of us in the room have to say subsequently. It is only by forming a coalition of dissent to that sort of reckless behaviour that we are going to get anywhere on that important topic.

Ms Robinson—There has clearly been a lot of discussion recently—and Professor McGorry has been talking about this issue quite openly—around the issue of media reporting of suicide. I would echo what has been said around the table, which is that we do need to be very cautious

about this. I think contagion is a real concern, and the research evidence continues to support that. The Mindframe resource that Judy mentioned earlier is a really useful piece of guidance, and it has been taken up by journalists in this country. It is also very similar to the sorts of guidelines that have been issued in other countries as well. They are very similar to the guidelines that operate in the UK and in other Western countries.

One thing we do need to be careful about though is that those guidelines do not at any point say we should not report suicide in the media or we should not talk about it; they need to say that we need to be very careful how we do it. Obviously we need to avoid sensationalist reporting, details of methods of suicide and those sorts of things that we know lead to contagion, particularly in young people. There is of course the concern that a lack of discussion can help perpetuate the problem we have around stigma and silence of suicide and perpetuate the myth that actually talking about suicide can increase risk. What we see are some contradictory views because talking about suicide openly in the media can contain risks if it is done in the wrong way but we need to be very clear that when talking to young people on an individual basis we need to be able to talk openly about suicide. That is one of the things we are trying to encourage young people to do.

We have to be careful in the media and use the media a little more cleverly. We can model ways for young people to talk about this in a safe and supported way. We can use the media, as has been said, to report some positive stories or messages around help seeking and good sources of help. Interestingly there is some data that shows that, following reports of suicide and things like that in the media where helpline numbers are put up, there is an increase in the use of those helpline services. There are opportunities to promote help seeking and positive messages. We should not shy away from doing that.

Young people are using the media to talk about suicide. Whether we as professionals like it or not, they are doing it. They are not discussing it in the *Age* or on the ABC news but they are using social networking sites, Twitter and all those sorts of things to talk about suicide and self-harm in the media. We cannot ignore that. As professionals we need to be a little cleverer about how we use the media in order to interact with young people. We need to overcome the fear we have all got around contagion. We really need to look at testing some safe ways of talking about this in the media and be more proactive in testing some safe ways we can use to model to young people positive ways of talking about this.

Prof. Milroy—I want to make one comment sort of allied to the media, which is perhaps what you have just touched on, and that is the proliferation of Internet sites around suicide. The problem is we do not actually have control over those things. So, as much as we may have guidelines for the media, we do not necessarily have guidelines for what people can post on Web sites, say in chat rooms and all that sort of thing. Really in a contemporary setting young people are probably more likely to use the electronic stuff than read a newspaper. I think that is an area where we need a little more investigation.

Ms Blanchard—I can comment on young people's use of technology for help seeking. The Mission Australia youth report showed that behind family and friends the Internet was where young people turned for support when they were going through a tough time. Over the last 10 years the Inspire Foundation has been working directly with young people to deliver online services through our REACHOUT.com website which, according to the Headspace community

awareness survey that was conducted last year, now has a 56 per cent awareness rate amongst young people. Increasingly information communication technology is where we need to be to ensure that young people are receiving positive and constructive messages around mental health and suicide prevention. It is an enormous tool and a setting in which we can promote positive mental health and wellbeing.

Ms RISHWORTH—I want to go to the collection of data. I think what I heard from both Helen and Daryl is that what we need to collect is national data but it needs to be good data and location specific. How do we collect better national data that is useful? What are some of the challenges—I imagine there are challenges; I am assuming we have not got this right yet—with some of the co-morbid deaths that occur with drugs and alcohol that also could be suicide related? How we are reporting that at the moment? It is being reported? Is suicide being underreported because of some of those co-morbid factors? How can we do that better as well?

Dr Mathews—I think it is clear that we do not have good data. Hopefully that will improve because I know the ABS are looking at changing the way they collect the data. There was a study done recently where the Queensland Suicide Register compared the data they had with data from the ABS on suicide rates in Queensland and the ABS data had underreported by a possible 16 per cent. There are lots of reasons for this. One that may be something that can be changed is that the coroners are actually not mandated to determine intent and often leave an open finding when it looks like a suicide and could be clarified a little more. There are obviously other reasons as well. The form of suicide—for example, car accidents—are often hard to determine. I certainly think there are ways we can look at making it more valid.

Dr Watson—We have included quite specific detail in our submission relating to improved reporting and also note that we made a submission relating to suicide to a Senate inquiry in recent times where we also addressed that issue. There is an absence of a central authority for recording and reporting this sort of data. There is inconsistent coronial processes, as we have already heard. That is by jurisdiction. Why come 2010 there cannot be agreement about that surprises me, as I am sure it surprises others.

Data is collected and sorted for different reasons by different people, which confuses things. The coding of data is tricky and sometimes absent, so, for example, the Bureau of Statistics does not report suicide for very young groups. The examples that Professor Milroy provided would be missed from that source and there is a lack of systemic resource in training and shared expertise around the topic. Given that we advocate doing more in this area, it would be nice to be able to evaluate that and to show that it is working. We think that the data does show that there have been some age groups where there has been a drop in suicide, but we have to say that with the caveat that the reporting and data around that is problematic.

Prof. Milroy—The other issue that needs to be put on the table in regard to community level reporting of suicide statistics in Indigenous communities is then the stigma that that community may experience by being labelled or identified. We vary from going to national data and then averaging to very community specific data. Maybe community profiles are also important for that community then to be able to access the need that they have in a better way and to look at how we fund that in a different way as opposed to necessarily publishing all the data that is available.

Ms RISHWORTH—I have a question for Michelle about young men. I noted the reasons that you indicated around their not seeking help—masculine issues. Is there any evidence to suggest that young men perhaps do not engage in as much self-harm as young women so they do not come to attention of medical professionals?

Ms Blanchard—I do not have access to the self-harm statistics with me today but my previous reading of them was that rates of self-harm were higher amongst young women.

Ms RISHWORTH—So they are more likely to perhaps come to the attention of health professionals through that?

Ms Blanchard—Jo is probably best placed to comment.

Ms Robinson—All the research indicates that self-harm is more common amongst females than males, but I think one of the issues with that is that females are probably more likely to come forward and seek help or to report self-harm.

Ms RISHWORTH—Right.

Ms Robinson—It might be picked up more readily in girls than in boys. We have done some work with boys' schools in Melbourne and we found rates of self-harm quite high amongst boys as well. I think there is an issue around reporting.

Dr SOUTHCOTT—Is it also an issue around the potential lethality of the attempts as well? I understand there is quite a gender difference between males and females.

Ms Robinson—Certainly, in terms of suicide attempts there is a difference in terms of methods chosen. Some work came out of New Zealand a little while ago that showed that the rate of suicide amongst females was increasing as was the use of methods like hanging replacing things like self-poisoning. Women were starting to choose methods that had previously been chosen by men and rates of suicide were starting to increase accordingly to such an extent that they thought that at some point those lines would converge and women would start to have a high suicide rate than men in that country. I do not know whether that has happened or not.

I think the other issue is probably what we mean when we talk about self-harm. Certainly, with respect to the boys we have spoken to, who we would say have probably engaged in acts that would harm them on purpose due to distress or frustration, those acts are different to the acts that we would necessarily associate with girls. So whereas girls might more frequently report cutting themselves boys might more frequently punch the wall or punch themselves in the head. There are issues around terminology and this leads to your previous point. Throughout suicide data collection and suicide research there are issues around definitions of suicide, suicide attempt and self-harming behaviour. Everybody uses slightly different definitions and that is challenging for us in research but it would also be challenging in trying to get reliable statistics up if we are all talking about something slightly different, it is really hard to get it a clear picture.

CHAIR—What is the relationship between rates of suicide and socioeconomic status? In your opening statement you touched a bit on it.

Dr Watson—It is not good to be poor in terms of mental health generally. If you are poor and you have poor mental health, your suicide rates are higher. That social disadvantage clusters and often persists across the lifespan and across generations. I think it is an area that, whilst we understand that it exists in terms of addressing the problem and targeting response, we have not done a very good job with in Australia.

In terms of the likelihood that there has been a drop in suicide rates in certain cohorts, that drop is vastly overrepresented in those from higher socioeconomic groups than those in lower socioeconomic groups. Not only are there higher rates, it may be that they are not responsive to the sorts of things that might be happening as well, so it really is a double jeopardy if you have poverty and social disadvantage.

Ms HALL—And the services available if you live in a rural area—

Mr Tanti—The point about service provision is that one of the things we notice when we first set up Headspace in the first 12 months was that we had more young women presenting than we had young men. In fact what has happened over time is that we have an equal number of young women and young men presenting to our centres, which is interesting, and in my experience of running health services what I have seen is that more young women present. So for me I think it is about the message and making sure that the message is pitched at the right level to attract the attention of young men, and I think we have had some success in doing that.

Dr Mathews—Going back to your question about socioeconomic status, I think that is also a variable that is difficult to define; people define it differently so it is difficult to compare across studies. My understanding is that the relationship is weak, but that is not surprising given the number and the complexity of the risk factors. I think that socioeconomic status is just one and, alone, is not predictive. So I think that the data is not really clear.

Prof. Milroy—In Indigenous communities, given the high levels of social disadvantage, it seems from some of the available research, particularly data that comes from the Western Australia Aboriginal Child Health Survey, that one of the stronger protective factors is the strength of culture and cultural identity. Those communities that have a strong sense of cultural identity seem to do better despite the economic disadvantage. So there are other factors perhaps that counterbalance that social disadvantage.

Dr Selway—When discussing socioeconomic groups we need to consider the rural groups which do have a higher incidence, as I understand it, of suicide, and I think that isolation and the lack of services can contribute to that.

Ms HALL—Picking up on the question that Amanda asked but probably from a slightly different direction, in looking at young people that have the dual diagnosis of mental health and alcohol or drug dependency or issues, do you think this is increasing? I would also like to know about the abilities of agencies to get in there and to provide services. How much of a blockage is the dual diagnosis to treatment or accessing services and the way ahead?

Prof. Milroy—I will make a brief comment about the younger age group. Again, from my clinical experience I cannot say that I have particularly looked at the statistics and the evidence recently but it seems that children at a younger age are starting to use drugs including things like

marijuana. We increasingly get children under 12 referred to the service, who are already accessing marijuana regularly, often through their parents, and there are actually no treatment services for that group at all.

Mr Tanti—One of the difficulties from our perspective is that services have become so incredibly specialised that it is very easy to not tick every box to gain access to that service, and I think comorbidity is one of those things. The difficulty with comorbidity is that the presentation complicates the assessment and so if you are substance affected then people are not sure about where you need to go. The problem with that is that you could fall between the cracks and you could end up in a much worse situation.

I think the opportunities, therefore, for me are in restructuring the services to make sure that all the expertise exists in the one hub. Headspace, as you saw this morning, is a very good example of having multiple agencies in the one space who can learn from each other but also ensure the patient gets the service—and that is the critical bit.

Dr Watson—Drug and alcohol problems are enormous, and are likely increasing. The groups they increase in are those with pre-existing mental illness, social disadvantage, poverty and poor help-seeking behaviour. It clumps together with the topic of this inquiry. It presents a complexity of treatment and intervention, but by no means is it impossible—challenging but still quite achievable. There is that problem that Chris referred to of service division and specialisation. The other concept we put in our submission is the idea that if you attend a service for help and if that service does not provide the specific brand of help you need then they must find someone else and direct you there.

It does not need enormous reorganisation of services. What it needs is that if you are in a human or help-seeking service, you try and fit the client who comes through the door with the best service available. Again, that is not very difficult because often they are geographically quite closely related and it is easier to take new referrals or new contacts from other professionals. So, yes, it is a problem in the high-end treatment areas such as in-patient psychiatry units, and probably the majority of people receiving treatment have comorbidity.

The last thing is that those things may be associated with impulsivity. Impulsivity is a particular problem when it comes to suicide. If one can delay, even by seconds or minutes, the thought of suicide from the action there is a major benefit. That is clearly going to be harder to do if one is intoxicated at the time. So that is an area for intervention, for sure.

Dr SOUTHCOTT—I would like to ask the roundtable for their opinions on whether we have made progress in destigmatising mental illness, whether we have made progress on improving awareness of mental health issues by family members, teachers, work colleagues and so on, and whether we have made progress in putting people in touch with treatment. We have spoken a bit about all of these things and, to my mind, we have been getting a lot better at them. But the representative from APS said that there has been no real change in youth suicide rates.

Mr Tanti—I think the work of beyondblue has been instrumental in raising the awareness of the issues in the community. One of the difficulties with raising awareness, as we have discovered in Headspace, is that if you do not have services then what is the point of having people aware that they may or may not have a mental health problem. We have made some

inroads into the provision of services through GPs, through psychiatrists and through other community services. But the area where we are sadly lacking is mental health literacy. That was touched on earlier on. For a lot of young people they have no frame of reference for what is going on with themselves. It is hard for them to understand whether they need a service or not. We need to do much more work and much more targeted work in schools. Certainly I think great work has been done, but could we do more? Absolutely.

Dr Graetz—Raising awareness has certainly provided difficulties around service provision, but it has gone a long way to setting the scene around mental health promotion, developing capacities for coping skills for young people and identifying services that are available. A good example is working in the school setting, where we have worked for a number of years. If you went into a school 10 years ago and said, ‘I want to do something around mental health,’ the immediate response was, ‘You want to talk about mental illness and the associated stigma attached to that.’ These days, we get very positive responses from schools who see themselves as clearly in this space, and they are clearly looking for some directions and support around these issues.

As Chris was saying, there is a long way to go. For example, many secondary school students will not know the difference between GPs, psychiatrists and psychologists. A lot of them certainly will not know what is available around local services, particularly in the mental health literacy area. Quite often the approach has been, ‘Let’s talk about mental illness’, and that has been a difficult starting point for schools. If you start from the universal point that everyone has mental health and then talk about it as being universal, that things will go up and down and that people will struggle from time to time, it provides a much better avenue for engaging young people in the longer term around talking about mental illness and where you might go to deal with that.

I think the situation is incredibly different from what it was, say, 10 years ago in a lot of community settings. I think that has a lot to do with organisations like beyondblue and others working in the area to raise awareness.

Dr Selway—Just for the committee’s information, MindSavers is an organisation dedicated to mental health literacy. Our team does courses in mental health first-aid certificates, youth and Aboriginal issues as well as standard courses. I would like if possible to read my statement now, because it seems to be a fitting time to do that. Just to set the scene, I would like to mention some research from Mission Australia’s national youth survey in 2009. They identified three top issues of concern for youth. Those issues were drugs, suicide and body image. Interestingly, 85 per cent of youth surveyed identified their friends as the first port of call when seeking advice. Based on that knowledge, MindSavers would want to see—and I am sure we would all want to see—that young people have the knowledge they need to help each other. Therefore, MindSavers advocates training to young people in high schools as mental health mentors—one male and one female—who teach and share their knowledge with their peers.

Under the current model, there seems to be an adult-directed type of educational approach, where it is mostly adults who deliver the information to young people—adult teachers, counsellors and mental health first aiders. What I am proposing is a more youth-directed educational model for early intervention in which youth are trained to directly share information with their peers.

Currently MindSavers is undertaking a small pilot project with young carers in Adelaide. We have given them a few hours of very basic mental health training, and we have utilised the youth beyondblue information to do that. The early results are very encouraging. This project design can be scaled up if necessary, but it really does meet the grassroots need for young people to get that information.

Our objective is to take mental health information to the grassroots level of the youth community by trained high-school students working in collaboration with their school counsellors and teachers. We are hoping that this early intervention strategy will help take vital information from Headspace and beyondblue directly to young people and that they will utilise it. Hopefully it will help save some lives in the process.

It is very important to remember that young people do not get up in the morning one day out of the blue and say, 'I'm going to commit suicide today.' Most often the 'evil twins', as I call them—depression and anxiety—are behind that. If we can raise awareness of those issues early and get help-seeking behaviour happening early, it may well assist the statistics.

CHAIR—We need a member of the committee to move that we accept the documentation tabled by Deborah Selway as an exhibit and received as evidence of the youth suicide prevention program. Thank you, Amanda. Does anyone wish to add to what Dr Selway has said?

Dr Watson—On the issue of awareness, I think it is easy to suggest that awareness has increased. Again, it is an area in which we do not fund the research and the evaluation of it effectively, so some of the agencies that increase awareness potentially should also have some money attached to do that.

We also need to be careful in saying that, if we increase awareness, services get swamped. We do not say that with other health conditions. If a celebrity gets condition X, people then come out in the next month or two and say, 'It's terrific that more people are presenting for screening or testing.' The message that has got to continually come out is: 'Help is available, you can get help and help works.' It is very tempting—and I am sure our college does it when we have a group of politicians—to say, 'We need more resources; we want to do this,' but there is already a lot out there that is very effective.

In terms of youth and awareness, I think the area to emphasise is building individual resilience. Some of that you can see in terms of community engagement, but particularly with youth the idea that you can be a resilient person despite adversity is something that we really need to focus on. If we are looking at some sort of measurement of our interventions in schools, how many more Australian kids feel resilient at the end of that intervention in education would be a wonderful thing to look at.

Prof. Milroy—On the Indigenous-specific situation, there has been an Indigenous mental health first aid course. It was developed a couple of years ago and it has been rolling out. I do not know what the full evaluation is, but it has certainly been very well received. That is to improve mental health literacy for Aboriginal communities. A lot of Aboriginal communities have also received a lot of suicide prevention training but they still do not have any services. So it is putting the cart before the horse, I suppose. If they keep having more and more suicide

prevention training but there are still no services at the end of the day then it is a real waste of money.

The other issue for some of the remote communities is not just the lack of services but the appropriateness of the services. We did a survey in WA looking at developing an Aboriginal mental health service, and, in one of the remote communities, the first point of contact for any mental health problem was the police, which really is quite inappropriate.

The other point I would like to make is that some of the remote communities, particularly in Western Australia—talking from that experience—may have up to 200 visiting agencies providing different services, and there is a sheer lack of coordination of services and people going in. If you have got 10 different government cars rolling up to your house in one day to provide you with a service, I do not really think that is very useful.

Mr Tanti—Can I just echo Helen's comments. I am not convinced actually that there are enough services available. My main experience is with Headspace in this space. At a growth of 45 per cent per annum, we are now on waiting lists. That is very different to thinking there is enough money in the system. I think there probably is enough money in the system, but it is just badly coordinated, badly allocated and badly evaluated. I think that is where we need to be. We need to be looking at the systems and the services and bolting them into each other. We need to make it as simple as we possibly can for the consumer.

Prof. Milroy—I have one more comment about services. For some of the child and adolescent mental health services, the waiting list is over 12 months.

Ms Robinson—On the question of 'Have we raised awareness and reduced stigma and those sorts of things?' I think the evidence does tell us that we have done that. The research is out there that says that we have been doing that quite well over recent years. What is much harder to know is whether those sorts of things have actually led to changes in behaviour. As a researcher, I would say that we need more research emphasis, and properly resourced and designed research, to look not just at whether we have raised awareness and reduced stigma but whether that actually has led to the ultimate changes that we want to see, which are increases in help seeking, increased engagement in treatments and services and consequently a reduced suicide rate. Those things are much harder to look at, but we need to do that properly.

I think that the evidence to date, though, says that, in addition to awareness raising and destigmatising and campaigns that do that, we need to take on board some more targeted approaches with young people in order to engage them properly with services if we really want to encourage and increase help seeking. We have trialled some early detection models in schools where we have gone in and piloted some screening or early detection models to try and identify young people who might be at risk and have not already come forward. We have identified a significant number of young people who are at risk but have not previously sought help and we have then been able to link them in with services. So I think there is some evidence to say that, in addition to those sorts of awareness-raising and destigmatising campaigns, we need to take on a slightly more proactive and more targeted approach with young people.

Dr SOUTHCOTT—I would like to ask Dr Watson a follow-up question related to resilience amongst students and starting much, much earlier than what we have been talking about. It is my

impression that educators are really putting their minds to this. Schools will do it on an individual basis, but the broader education system is also thinking about how we can equip the educators, the teachers, to build resilient students, people who will be able to take setbacks and that sort of thing. I would be interested in the college's view and perhaps to hear from anyone else who might have anything on what sorts of benefits this approach might have.

Dr Watson—We have given some examples of programs that seem to work around that. I would like to emphasise that it is worth while targeting very young people with a view to building that resilience, and we would strongly encourage the rollout of those sorts of programs, particularly at schools. At schools it is important, though, to be rolling those out fairly early. The disadvantaged group that I was talking about before are also the group that leave school early, so you can miss some of those people. So, yes, if you can roll that out, you will get those benefits in resilience. But, in doing that, you also need to realise that there are still going to be people that miss out on those sorts of programs for whatever reason and you still need to have catch-up services available.

Dr Graetz—I would like to indicate to the committee that there are programs currently in primary schools that also target resilience. They are under KidsMatter, a national pilot which has been extended in partnerships with states and territories. Clearly there are a number of programs that schools have been using for some time, and they are generally resilience type, competency based programs. Primary schools are very germane to this area because they have the curriculum space to be able to do this. In high schools it is very difficult to get curriculum space. Also, we are dealing with competencies that are developmental. Like with maths and literacy skills, you cannot go in there, do one session and say, 'There you go—there's your competency base and you're developed.' The skills are incremental and you do have to provide a progression through the skills.

It is also important that, at that younger level, the messages about dealing with adversity are not just directed at kids. As important as that is, it is also about the important adults in their lives, the parents and teachers, being able to respond to their social and emotional needs. We clearly have lots of teachers in primary schools who get a message from parents saying, 'My child has ADHD,' or, 'My child has depression,' and quite often it is left to the teacher to determine how to respond to that. Under KidsMatter, which beyondblue, the APS and the Department of Health and Ageing are partnering with, it is really about saying to teachers, in terms of responding to kids with mental health difficulties: here are the strategies not only to keep them engaged in their schooling, which is teachers' core business, but also to connect with local community services.

This is always on a case by case or school by school basis. The service profile is very different from region to region, but that coordinated approach focusing on both the individual and those important figures in their lives, parents and teachers, is much more effective than simply focusing on just the child, and the research has pretty clearly shown that. So we are very clearly starting earlier. In fact, KidsMatter is actually going into early childhood services with the same framework. It is around not only individual kids, and they do have competencies at a very young age around peer relationships and things like that, but also parents and teachers, who are more and more looking for information on how best to support their kids' needs.

Dr Selway—On resilience, we also need to remain aware that there are a humungous amount of pressures on young people. Are we building resilience for them to be tougher to handle the

pressures, or can we find a way to take the pressures off them? I want to get back to some of the statistics from Orygen Health Research Centre—Betty Kitchener and Tony Jorm—on mental health literacy and mental health first aid. In a study that looked at the public reception of mental health first aid they reported that 78 per cent of those trained in mental health first aid, after about 19 to 21 months, had better outcomes than would otherwise have been anticipated for those people and for the people whom they had contact with. I think that is worth sharing with the committee.

Mr Tanti—Can I just make a comment about secondary school education similar to Brian's comments around KidsMatter. The Department of Health and Ageing also funds the MindMatters initiative, which is run through Principals Australia. Headspace is about to be engaged to work in partnership with Principals Australia to reorientate MindMatters. MindMatters is essentially a professional development exercise for teachers, and the missing bit has been working with students. Headspace will work with Principals Australia to shift that. So there is also some work occurring in secondary schools and has been for the last 10 years.

Dr Mathews—I agree with what has been said. A lot of what has been done has been done at the community level in broad educational initiatives. I want to echo what Jo said about us also now needing to think about more targeted population groups—that is, targeting the education and interventions towards the high-risk groups and doing much more work at that level. I think that is what is missing from the current framework.

Ms Robinson—In response to that, and leading on from some of Brian's comments, I think one of the things we know is that young people who engage in deliberate self-harm are one of those groups who are at high risk of going on and engaging in suicidal behaviour and suicide. We know that when those people do seek help one of the first ports of call for them is teachers or school counsellors. We also know that school counsellors generally feel quite overburdened and overstretched and that they feel overwhelmed and underskilled in terms of responding. Some specific training around managing young people who are at risk and working with people who engage in self-harm for those sorts of populations would be incredibly beneficial.

Miss Baldwin—I would like to point out that a lot of schools have school counsellors maybe only two days a week. That is definitely something lacking.

Ms RISHWORTH—One group you imagine would also be high-risk, especially when it comes to youth suicide, is homeless youth. Obviously they have a lot of the underlying factors we have been talking about—low socioeconomic status, not a lot of support from family and friends—and perhaps are not very skilled at seeking assistance. Has there been any work done on homeless youth and the link to suicide? Maybe that is a hole in the data; I am not sure.

Mr Tanti—That leads to the discussion we have just had about specialist or more targeted services. The public sector is very geared towards providing services for the pointy end of the spectrum—the homeless, the seriously mentally ill et cetera. What does not occur in the community is the provision of services for those people who do not present with what in the past we have considered high risk. I agree with the comments that we need to, in a sense, re-engineer the approach to be a bit more targeted, but we are very, very specialised. I just think the system needs to be tweaked a bit. We do not need any additional services to focus on that end.

Prof. Milroy—I cannot really comment on homeless youth and the suicide statistics but I will make a comment about the homelessness issue being a little bit hidden for Indigenous youth because they often move around from household to household but are essentially homeless.

Proceedings suspended from 2.19 pm to 2.48 pm

CHAIR—We will begin our second session with topic 2: how can we prevent youth suicide? This session aims to investigate what early intervention programs work, how and why they work and what we can learn from both successful and less successful intervention programs. I now invite all the participants to give a three-minute statement and then we will proceed to questions and discussions.

Dr Watson—As we said before the break, we have some concern that we have not done the systematic evaluation of the National Suicide Prevention Strategy to know whether it works, and today you have heard different views as to whether the rates are going down or are stable because of those concerns. What can be done to improve things? We think there is a particular need to focus on risk groups and risk factors. We have already heard quite a bit today around Indigenous populations, and I just want to emphasise that we agree with the views put forward about that. In terms of other risk, we need to keep in stark relief that depression is a major risk factor associated with suicidal thinking and completed suicide. Earlier on Ms Rishworth asked a question about women attempting suicide and coming to attention. Maybe one of the downsides to that is that we do not have adequate postdischarge support for people who have survived a suicide attempt or have presented to services with self-harm, and that is an area that we can improve. In terms of suicide I think legislators need to be congratulated on things that they have done previously in reducing access to the means of suicide—issues related to domestic gas and access to firearms in Australia, which has been really quite important. In our submission we note the increased availability of potentially dangerous drugs such as paracetamol. They are areas that legislators might need to pay attention to in terms of prevention models, as they have done before.

Dr Mathews—As I mentioned earlier, we would like to see a greater emphasis on specific initiatives and funding programs to meet the needs of individuals who are at highest risk. We feel that, while the National Suicide Prevention Strategy has been very welcome, there has been too great a focus on education and population based approaches, so we would like to see an increase in funding of research and development and an evaluation of intervention based programs for the target group, the high risk group. There are a number of other initiatives we would like to see put into place: the development of protocols on discharge from emergency or mental illness treatment facilities. We know that discharge from hospital after a suicide attempt is a very high risk time, and I believe we need protocols to support people at that time—the research suggests for up to 12 months. I think that that needs to be focused on a collaborative care approach between agencies, not just on coordinating and monitoring but also on working on an agreed model of care. We think there should be standards for training and service management. We need to increase the competence of health professionals but also their confidence to work with this group—that is really important—and ongoing research on interventions at the individual level.

Ms Robinson—The key points for us are that we would like to see greater priority given to high risk groups going forward, including people with mental health problems, previous suicide attempts and self-harm. We would like to see a much more proactive approach around getting

young people engaged in services, and that would include through early detection programs, and definitely a more strategically driven research agenda with an emphasis on building a proper strong evidence base around intervention research. We would like to see more attention given to more targeted approaches, focusing on those people who we know are at risk and in settings where we can have ready access to people. We know—and as we have heard from around the table—suicide is strongly associated with mental health problems, in particular depression and anxiety, and that risk is highest in the early phase of illness. We also know that effective treatment at that time can reduce risk, so we know that early intervention and early treatment can reduce suicide risk. So, if we can intervene early, we stand our best chance of reducing suicide risk in this population. Again, we know that young people find it hard to seek help and that the likelihood of seeking help reduces as risk increases. So, in addition to broad campaigns that we have seen a lot of that aim to promote help seeking and create awareness and reduce stigma, we would suggest that we need a more targeted and more proactive approach to facilitate help seeking in young people.

I think, though, if we are identifying and promoting help seeking and identifying people at risk that we also need to be in a position to provide appropriate support, be that counselling, monitoring or more intensive treatment or services. So we need more service reform and better and more training around assessing and managing risk for front-line staff. That would also include, I would suggest, school welfare teams. Just to reiterate what Rebecca said, we also know that people who are at risk frequently get turned away from services, be they specialist mental health services or emergency departments, following a suicide attempt. We know that a significant number of people who present at an emergency department following a suicide attempt do not get a proper psychiatric assessment and they do not get proper treatment. Those people are actually at significant risk of a repeat attempt, certainly in those early weeks following the presentation, but that risk actually persists throughout their adult lifetime. We know that the outcomes are better for people when they do get that treatment and that proper assessment.

But leading on from that we really need to prioritise testing, effective interventions, including e-based interventions, SMS based interventions and those sorts of things which are popular with young people. Research has told us a lot about the epidemiology of suicide, so we know a lot about risk factors and things like that. But we do not know very much about effective interventions, and I would suggest that needs to be a really strong future priority—for example, interventions for mental health problems and for people following self-harm or a suicide attempt. There is already some good evidence there that gives us an idea of what works in this field and with these people, but much more work is needed. We need to work collaboratively on this. In research terms, suicide has a low base rate so, statistically, it is quite a rare event. So if we have a more strategic approach and if we work collaboratively in terms of better funded, better powered studies we will have a much better chance of actually developing a good idea of what does and does not work in preventing suicide in this population.

Ms Blanchard—The Inspire Foundation believes that a really integral part of suicide prevention is mental health promotion and prevention, sitting alongside an early intervention approach. So we would recommend strategies and initiatives that start to address some of the social determinants of young people's mental health and wellbeing and that enhance protective factors—things such as self-efficacy, help seeking and social connectedness. In particular, we would see that new and emerging technology, including the internet and mobile phones, as an

enabler of young people's mental health and wellbeing and an important setting in which mental health promotion, prevention, early intervention and treatment can take place. We see that consumer participation and, in this case, young people's participation should be considered as essential in the design, development and delivery of any interventions. We also see that it is essential that collective responsibility is taken across sectors—non-government, mental health service providers, corporate and government. We believe that technology and a shared vision for promoting the mental health and wellbeing of young people offers us an opportunity to do that. It not only provides the opportunity for each organisation to take responsibility for what they are good at but also offers a really seamless approach for young people, less confusion about where to go to get help, who to get help from and how to get help.

There are some fantastic e-health initiatives in Australia, such as MoodGYM and e-couch out of the Australian National University, the youth beyondblue website, the Headspace website and Beacon et cetera. But there is a real need to actually bring those together under an e-health platform that works across the spectrum, providing promotion, prevention, early intervention and treatment activities, specifically in the area of early intervention and treatment. There is an opportunity to provide access points online through organisations like Inspire and our REACHOUT.com initiative, plus also going into the social networking spaces where young people are, such as Facebook and Twitter, which young people are using on a daily basis to actually create conversations around mental health, wellbeing and indeed suicide.

There is also an opportunity to ensure that professionals, parents, carers and the community are aware of the role that technology plays in facilitating some of these conversations. There is a real disconnect between young people's day-to-day experiences and the experiences of those around them. So, essentially, we are of the opinion that technology could actually be a really important space in moving forward.

Mr Tanti—I guess I am stating the obvious when I say that it is a very complex problem and there is not just one solution. One thing that concerns Headspace, with some of our experience in the last three years, is the structural and systemic problems associated with service delivery, which are actually adding to the problem rather than assisting with the solution. My experience is that in some instances the funding serves the interests of the organisation rather than the interests of the community or the client. The service system is fragmented and specialised. People are often in competition with each other, so they do not cooperate around the interests of the client. Community services are not necessarily well linked to specialist services. There is a complete disconnect when the presentation is more complex, and the client often gets left or the referral does not occur. There is very little community planning, in spite of the rhetoric around partnerships. Differences in philosophy, treatment models and an unclear evidence base mean that often services cannot see a common way forward and the client is caught in the middle. Funding is incredibly complex and provided through multiple government agencies, with little coordination within departments, between departments and between the Commonwealth and the states and territories. In my view there is a considerable waste of what is often referred to as a scarce resource. Most young people at risk are not at risk enough to access public mental health services. Most young people do not have a frame of reference for what is going on with them, and there is limited work being done in the schools to develop mental health literacy.

Headspace has made some inroads into providing a non-stigmatising, community based and informed integrated service structure that is youth-friendly. Importantly, in all the 30 Headspace

centres young people have been involved in the design of the centre and form part of the advisory structure for management and the consortium partners. Most importantly, the evidence suggests that most young people value our services. Under the umbrella of Headspace, multiple organisations, including schools, come together to provide a one-stop shop for young people. This is not necessarily an easy process, but it is a process that is transacted within that community. Twenty-three thousand young people have been seen in the last 18 months and that number is growing by, on average, 40 per cent in each centre. All of this happens on a recurrent funding base of \$450,000 per annum per centre.

The public sector deals with the most complex presentations, so those who are seriously at risk get a service. Other than Headspace, there are very few youth-specific services for this age range that provide face-to-face support to clients who have high-prevalence disorders. We need to engage young people in a way that is relevant to them and not to us. This would involve the utilisation of various mechanisms, such as confidential, low-cost, face-to-face counselling, mental health education in the schools, e-services, which have just been mentioned, including online counselling, and public awareness campaigns.

Prof. Milroy—I agree with all of the comments that have been made so far. I will address some of the issues from an Indigenous perspective and I will make one comment about children in general. From the Aboriginal perspective, we tend to talk more about social-emotional wellbeing rather than mental health or mental ill health, so we need to think about a shift from the negative language, or the deficit model, to something much more positive and strengths based. With some of the language that is around at the moment, shifting from ‘suicide prevention’ to ‘life promotion’ as a more positive way forward is important. I agree that although Indigenous people represent an at-risk group we also have a lot of natural resilience, and there are a lot of programs that have worked incredibly well that other people could learn from. So, instead of looking at Indigenous people from the deficits perspective, we should actually look at Indigenous people from the strengths perspective as well.

From a national perspective, of course one of the big issues that confronted Indigenous Australians recently was the apology by the Prime Minister. It was very symbolic. If we are really going to look at the whole issue of Indigenous youth, then what does a young Indigenous person in Australia today aspire to? At the moment we still do not have a national identity; we have nothing that Indigenous young people look up to to feel proud of in this country. Unless we address some of those things at the national level, working down at the grassroots level in communities, with all the levels of poverty, dysfunction and distress, all we are going to be doing is managing chaos and dysfunction instead of actually promoting what should be a very proud heritage for all of Australia.

Having said that, I also think that, when we look at the evidence, we are only looking at a small part of the evidence, and it tends to be very Western biomedical, and we often fail to see the evidence provided by the cultural approaches which communities are quite positive about pursuing. So I think we have a differentiation between what is good evidence and bad evidence and what evidence actually gets privileged. From an Indigenous perspective, Indigenous science, I believe, is just as important as Western science when you are looking at the evidence base.

I am not quite sure who coined this joke, but someone made the comment that Indigenous communities have more pilots than Qantas. I think that we have to be aware that, if we are going to change the population structure for Indigenous families and actually grow our young people into being old elders who then can support families, we need a very, very sustained and generational approach that goes well beyond funding cycles, policy frameworks and governments. Unless we have that joined-up funding that is sustainable over time, I do not think actually of these short-term programs are going to make much difference given the level of risk that is there.

From the children's perspective, while we overfocus on the tipping point in adolescence, we are really failing to meet the needs of the children at a younger age where intervention possibly could be more effective. I would actually like to put forward a complete overhaul of the child mental health system throughout Australia, because it is very underresourced and underfunded and probably fails to meet the needs of most children within the community. In fact, I think we only see something like four per cent of children in need, or something like that. To have long waiting lists in child mental health services is just not appropriate in a child's life.

Ms Finn—I too would like to reiterate support for the comments made so far in this session. It is clear from a public health perspective that suicide is a complex thing, and, unfortunately, there is not going to be one single bullet and one single thing that we can do to prevent suicide. We need to be working across the lifespan with different population groups in a targeted way as well as in a broad population based way to ensure that we continue the work that has begun around awareness raising and changing social attitudes so that we can talk about depression and anxiety and that those two then mean that people will access help early and stop this escalation into the tragedy that suicide is. Just to reiterate beyondblue's position regarding the importance of the work in the area of depression and anxiety is making a very important contribution to suicide prevention.

Dr Selway—I read my main statement earlier but I would like to make a couple of comments. I certainly agree with what has been said around the table. Firstly, I am an educator, so I am very passionate about the role of education as an early intervention strategy. While there is some research out there, I would always back and support more opportunity for research around this so that we are actually targeting very clearly the target group that we need to target. I would support that very strongly.

In terms of a general comment: when we think about young adults, we often think about them in schools, but there are young adults out there in the workforce who are vulnerable to bullying and other types of harassment and toxic work environments who we need to be mindful of and perhaps think about how we can touch them, get the information to them and going to the information to businesses as well to ensure safe mental health environments for workers, and particularly for young, vulnerable workers.

CHAIR—Thank you for your statements. I will kick off with a couple of questions. My first question is to Professor Helen Milroy. Of course, anyone else can assist in answering it. You touched on Indigenous communities and the services that are available and how culturally aware the services are. Would you be able to tell us a bit more about other cultures? Do we have enough services that are culturally aware? For example, in many cultures, any advice and social services are basically given by the family and by elders, and having an outsider come into try to

assist and help could be fairly traumatising for that particular family. Also cultural differences that people are torn between can cause a lot of anxiety and depression and a whole range of things. Are we dealing with these adequately?

Prof. Milroy—I guess it is a bit hard for me to comment on the broader perspective, although there is a very, very large multicultural mental health type workforce out there and there are certainly a lot of programs that try to promote cultural competency in services and culturally safe practices.

In particular, we now have a national framework in the training of doctors called the CDAMS Indigenous Health Curriculum Framework that is particularly looking at cultural competence for Indigenous health. We also have many other frameworks that are meant to be included in training. I will leave our College of Psychiatrists reps to talk about the college perspective. We have certain training requirements and you have to meet those needs so that you can service the whole community. I think the complexity for Indigenous people is that we have the legacy of colonisation as well within our own country. So it presents a slightly different issue than the general multicultural issues that may be present in psychiatry.

In regard to service provision, part of the difficulty for a lot of the Indigenous communities, particularly in rural and remote Australia, is that they do not have a sustained workforce. They may have a practitioner that only comes for six months. By the time they become a little bit more confident in working with that community, they have gone. So they are constantly retraining new people. I think that fly in, fly out service mentality or the constant turnover, particularly of mental health staff within a rural setting, is problematic. If you look at the provision of child mental health services, for example, you could have one child worker in the whole of the Kimberley, which is almost a joke. So there is really a gross inadequacy of people on the ground as well.

Dr Watson—If I could emphasise that we have moved in the college to have the training requirements that Professor Milroy talked about. I also note that the sort of work we are talking about is very language rich, so when you are talking about culture you are also talking about the crossover into language. Some of the specific problems that arise, for example, with general practitioners who work with a particular cultural language group would benefit from specific supports around that. The complexity around this sort of topic is that they are also working in disadvantaged areas, probably earning lower incomes, and for them to be able to access further training and further supports around that, the tying things together that you have already heard about becomes quite complex.

The other group that I want to emphasise is the more recent arrivals. We have heard about the legacy of the Indigenous community from an invasion perspective, but there are also people—refugee communities—who bring with them exposure to trauma and problems of very a complicated migration nature, and that brings new problems. The nature of Australian society is that those problems are always there for us in cycles. We should not forget those things.

Prof. Milroy—I have one more comment in relation to the Indigenous perspective. One of the things that I think we fail to grapple well with in mental health and the provision of support services is the whole notion of traditional methods. I think that is probably a problem across cultural groups as well. What is the evidence for traditional methods actually providing recovery

or support or whatever that enables a young person to continue on in their life and promote their resilience et cetera? I think the role of traditional healers in Indigenous society has been an underutilised resource and it is not well recognised.

Dr Mathews—I would like to add to that to say that we would like to see suicide prevention programs for Indigenous youth developed in that local community rather than these fly in, fly out programs that are very Anglocentric and do not take account of the cultural issues.

Dr SOUTHCOTT—There is a proposal on the table at the moment that the Commonwealth government take 100 per cent responsibility for funding in the area of mental health and also 100 per cent responsibility for policy. That has implications in areas that have been run by the state and territory governments, such as drug and alcohol services, some of the community health centres and some of the CAMHS equivalents in each state and territory. I would be interested in whether you think that will address any duplication or lack of coordination. What is your opinion of that proposal?

Mr Tanti—I would very much support that proposal with a number of conditions. One of the things the Headspace centres constantly find frustrating is the difference between the Department of Health and Ageing and FaHCSIA and the fact that the streams of funding that come through those departments are not coordinated. The other thing that I found striking in running a national organisation is that the service system is set up very differently in each state and territory. It would be terrific to have a national approach to mental health services. My concern is that if you run something out of the Commonwealth then it is not locally responsive. So there would have to be some mechanism to ensure that occurs. Having said that, we run a national organisation that is locally responsive, so I think these things are easy to do but probably a bit more difficult to do in the context of a very large bureaucracy.

Dr Watson—The college has been very supportive of a national mental health plan over an extended period of time. One of our concerns is that there are inconsistencies, which have already been spoken about, generated within individual jurisdictions that would seem to be unhelpful. We have not formed a specific view around the funding model, but I can say off the top of my head that it seems like an interesting idea that is certainly worthy of exploration providing that it meets the problems that Chris has already raised. Regardless of where you put the boundaries around those sorts of funding packages, there is always going to be some boundary service that needs to be sorted through. I think it is a very interesting development and we would like to look closely at it in the coming weeks.

Mr Tanti—The other comment I would like to make is that area mental health services are generally attached to public hospitals. The experience of most services that I have come across and deal with in Headspace is that their budget is slowly eroded. So that they are not actually receiving their full allocation because it goes into propping up the public hospital. This is something that cannot continue and community services probably need to be separated, from my perspective, from acute services and hospital based services in order to maximise the opportunities in the community for people who have a mental health problem.

Dr SOUTHCOTT—You might not have developed this idea, but do you think that the relationship should be more with a primary healthcare organisation than with an acute care hospital?

Mr Tanti—It depends on how the primary healthcare organisation is configured. If we are just reproducing the divisions of general practice then I do not know that that would necessarily work. The main relationship of the mental health service needs to be with its community. Again, I will reference Headspace. One of the things that mental health services have started to do in the Headspace areas is be a lot more responsive to the other community services and therefore the clients in their region. They are able now to meet their needs. I am not sure that a relationship with a very large primary healthcare bureaucracy is the way to go. Certainly, there is currently a very problematic relationship with the hospitals.

Ms HALL—Isn't the purpose of delivering the services focused around the client? If our services should be client focused, shouldn't there be a process put in place where you link the acute care with the community care and there is a set process for how that client will be able to get these services that they need right from an acute episode through to getting their life on track in the community? Shouldn't there be an effort put towards that?

Mr Tanti—Sorry, I was not fantasising when I was talking. I absolutely agree with you. There needs to be tiers of service that a client can step through.

Ms HALL—And they are linked.

Mr Tanti—Exactly right. Currently that does not exist. If you are a mental health clinician, you are generally working in isolation from your in-patient unit, from other community services and from services outside of your mental health service. When I think about it, it is a very simple restructure. When I think about it industrially, it is a very complex restructure. But there is no reason why you could not duplicate the Headspace model in other areas of health or in other age groups to manage the relationships with other community services. Helen and I were talking in the break about some Indigenous communities where myriad—240 or whatever—different service providers come into a community and provide a service. That is an absolute nonsense. There is currently no coordination of those services and it is incredibly complex, and the clients cannot find the services themselves. If we were clear about the structures in each community, we would certainly see more young people and more people getting services generally.

Ms HALL—It is more obviously in those Indigenous communities but, in one sense, it is like that in the community generally—is it not?

Mr Tanti—Yes, absolutely. In our Headspace centres that exist in regional and remote parts of the country, the relationships are entrenched. You have an immediate relationship with the hospital, with community health and with the GPs, and people are known to you. It does not mean that it is easier to reorientate services, but in the cities it is a much more complex game.

Ms Blanchard—One of the things that Chris mentioned is the opportunity to have an integrated system that young people can step through. Information communication technology and an e-health platform would add tremendously to that particular integrated model. That opportunity would provide the first port of call for a young person to get information, advice and support to help themselves and to help a friend, and then they could make the transition to a face-to-face service—like Headspace, like Orygen or like a community health service—so that they can get the help and support they need and then having an integrated platform that they can

come back to as they start to get things back on track and maintain positive mental health and wellbeing.

Ms Robinson—We know that suicide risk is greatest at the point of entry into a service and the point of discharge from the service. The fewer chinks there are in terms of a pathway through care, the less suicide risk there is also.

Dr Selway—Could I comment on the e-service that you are discussing. I think it is a fantastic idea, but I would like to add a couple of comments from the young carers that I have been working with who said that you need to have access to the internet. When we are looking at rural and remote access that can be difficult, particularly for lower socio-economic groups. We say, ‘Go to the library,’ but there is a reluctance to do that in case their peers see that they have gone to Headspace or to beyondblue. That was a comment from some of the young people in one of the groups that I was running.

Dr Watson—I would like to pick up on the funding issue that Dr Southcott raised. If we move to a change in Commonwealth-state relations around how these things are funded, it would be really helpful to have a recommendation that organisations represented around the table are consulted on how that is going to be rolled out and the potential problems that we can hopefully overcome—not necessarily consultation about whether it is a good or a bad idea but how we can make it work. There may be some very positive things about some of those changes, but I think you have already heard today some of the reflections on the potential problems that may arise in terms of implementation that perhaps a roundtable like this could go a long way to help to fix. Let us not forget: whenever you bring those boundaries in, the highest risk groups around suicide are the first disadvantaged. That does not mean that that has to be a problem; it means that you have to get clever about capturing those groups and keeping them engaged and in services.

Prof. Milroy—I just want to make one comment really. I guess the emphasis in the last couple of years has been to promote or to use primary health care as a better access point for mental health problems. Dealing with suicidal adolescents or mental health problems in a primary care setting is very, very difficult. It actually requires a significant amount of time. While we still fund health services, particularly GP services, for small allocations of time, I do not think that we are ever going to quite get the services that we really require at the primary healthcare level.

Ms RISHWORTH—My question follows on from that. In a primary healthcare setting you are really looking at a large variety of staff and the confidence of those staff to identify suicide risk. Even if they feel confident about identifying suicide risk, they might not feel confident about knowing where to go from there. In my experience I have seen a response that indicates that if a person is a suicide risk they must go to an acute hospital setting, which can be detrimental. How do you improve the confidence of the primary care staff? They are not the mothers and fathers who are identifying suicide risk. People who are able to identify suicide risk need to know where to go after that so that they can tolerate the risk of going down a non-traditional pathway that could be much more beneficial in the long term. But primary healthcare workers do require a lot of confidence to be able to do that. I am quite interested in people’s comments on that.

Mr Tanti—There is the issue of confidence but, in addition to that, there is also the time issue. One of the problems in primary care is that everyone has a 15-minute slot and if you are

presenting with suicidality you are going to be in there for longer than 15 minutes. The GP is immediately thinking: how do I see my next patient and who do I refer this person to? The experience in Headspace is that, because there are a range of practitioners on-site, the GP can make the immediate referral to a youth worker, who can potentially move that person to a psychiatrist who is on-site, or to a specific practitioner who is trained in mental health. So they can move a client along and they can see their other patients. As you are well aware, primary care practices are very, very busy, and I think they need enough knowledge to get them through that interaction in a way that is safe for them and in a way that is safe for the patient. But beyond that, there needs to be someone or some structure to deal the complexity.

Dr Watson—I think you have hit the nail on the head in terms of your question. Anybody who is doing any filter of that, including primary care, needs to be able to access some form of specialist service readily and easily, whether it is on the same site or whether it is through prompt response. In terms of the funding research hole, that is where it exists at the moment. That then drives what you are describing, an inappropriate referral, to acute hospitals, which are then unhelpful. They then get subjected to criticism that they do not have appropriate protocols to address it, and you have this cycle of dysfunction that occurs around that.

How is it that we are still talking about our inability for people in primary care or other human services to access appropriate services in an appropriate time frame? Some of the discussion today has been about months or a year of waiting lists. That is not happening for other serious health problems in Australia. The fact that it could still be happening around youth with depression, anxiety, suicide, drug and alcohol problems just beggars belief. So how do you stop leapfrogging that? You resource that appropriately so that it is readily available and then you check that it is working well and that there is evaluation there and you do all the other things that need to happen. You are 100 per cent right: those sorts of problems should be able to be treated outside of big, tall buildings.

Ms Robinson—In addition to that, I suppose one of the other points is that not everybody necessarily needs to be referred on. Many people will present with a mental health problem or in crisis that can be managed in primary care. In our experience many professionals, including general practitioners, are not very confident in assessing, managing and holding risk. They are more than competent but they are not confident, and that is our experience.

One of the most effective suicide prevention strategies that has been shown internationally is the improved training of general practitioners in assessing and managing young people, or people in general, at risk of suicide. That can lead to a reduced suicide rate. Some of the strongest evidence in suicide prevention is around GP training. So we can better train people and better equip them, and give them the confidence to hold young people at risk. Young people might just need monitoring or some supportive response. When people present to services what they really want is their story to be listened to. They want some empathy and some support. Some people will need specialist mental health care but not everybody will.

Ms RISHWORTH—So in answer to that, you are saying that maybe if we train more then that could lift the confidence levels.

Ms Robinson—Absolutely, and we have done some training—not with GPs but with school counsellors—around that, and we were able to show increased confidence and increased

perceived skill in managing and assessing young people who were at risk of self-harm in a school setting. We could not show a difference in young people's behaviour but we could show that professionals felt better skilled.

Prof. Milroy—You need a well buffered service provision. A practitioner with all the training in the world cannot be confident if there is nothing that is going to support them.

Ms RISHWORTH—Absolutely.

Prof. Milroy—And in the rural setting you end up with young people being transferred down to the main cities under the Mental Health Act because there is no backup.

Dr Selway—Thinking about after the service, if you identify somebody who is at quite high risk of suicide, you get them into some treatment, then the revolving door happens and they are out in a few days. Where do they go? These backup supports after these young people are out of care—the half-way homes, the services to support them when they are out in the community again—are lacking.

Dr Mathews—There is some research that was released recently, that demonstrated good outcomes for a case management type of approach when people were released from a service or a hospital. I think this research was based on two phone calls per week and one face-to-face meeting per week over a period of time. It showed reduced hospital rates and improved mood and general wellbeing.

ACTING CHAIR—Just on the point that was raised earlier, the national Preventative Health Taskforce cited some research saying that 96 per cent of Australians have a medical home, but in the context of health reform the Victorian premier has been saying that 10 per cent of patients who present at emergency departments do not have a relationship with a GP. A lot of those are younger people. How do you address the fact that there are these people? Ms Robinson mentioned the point that equipping general practitioners and enabling them to deal with mental health issues has a lot of benefits, but how do you deal with the fact that a lot of younger people do not have a relationship with a general practitioner?

Prof. Milroy—They may have a relationship with a school. I think we have underutilised the schools enormously. My experience working within schools in a mental health setting for some 20 years is that we have really downgraded the school support services. We have very few school psychologists working in the schools. We get referrals to a child service by a school psychologist who has not even seen the child. We have this captive audience where we could much better manage both children and young people. We could link them up with services if we utilised the school system.

Ms HALL—The problem there is that it varies so much from state to state. Some states will have really good resources and put considerable effort into providing those services, and other states really do not want to have anything to do with it. I suppose it is a problem with the system.

Dr Graetz—The sheer numbers of schools is an issue. So if you are talking about one in 10 or one in eight kids having a mental health difficulty, the professionals who are on the crisis management end, are never really going to cover the existing population. I think the training

around being able to better respond to the difficulties and having more confidence is really important but at the end of the day they will see clearly that they need links with our community health services. There is a really clear tension around that if you go it alone with either health or education. If you go with education and talk around getting better links to health services, local health services respond in a very cautious way. Understandably they say, 'We're not looking for huge referrals here.'

Similarly if you go with health services into education and you start saying, 'You can do this, this is what you should be doing,'—which quite often happens in that health has a clear view about what schools should be doing—schools are naturally reluctant because they see themselves as being left with the cart. I think that is probably where both health and education are worrying about being lumped with this problem, having to do it in isolation and go it alone.

Ms Robinson—That is an important point. Nobody wants to take hold of the issue around suicide prevention. There has been a lot of buck-passing and that happens in other countries as well. Nobody wants to deal with this alone and that is why I think one of the things that we do need is a cross-sectoral, across government, really collaborative approach where we are working together and supporting each other so that nobody feels that they are left holding this huge responsibility by themselves.

Dr Mathews—I would like to add to that. I think it is a problem that there are different levels of access to school psychologists, for example across the states. I think that it is complex and thinking about how to fix it is difficult, but we do need to discuss it because it is a problem. Some schools have one psychologist for two days a week across six schools. That is just outrageous.

Mr Tanti—What we have found is that each of the Headspace centres has a very strong relationship with schools in their region. Once the issue is identified within the school there is a clear pathway between the school and the Headspace centre. I do not think that we can expect schools to do everything. There are a range of things that we should be doing with students and partly that is about professional development for teachers. It is also about working with students and helping them to identify mental health problems and working with parents to give them an opportunity to understand what it is that is going on for young people and talking generally about adolescence and some of the challenges of adolescence. I think we can all forget about what adolescence was like for us—I am still in the middle of my adolescence, so I am very familiar with it! I do not know that it is all just about health professionals in schools. I think it is about community relationships as well and education.

Dr Graetz—I think the role of Headspace and even KidsMatter is that they actually broker relationships with health and education. They prove very successful because on the ground it is really interesting we get health services, CAMS included and divisions, who say they want to work with schools but they are not sure how to go about doing it. Education is saying, 'Yes, we want to work with health,' but they are not sure how to do it. I think there are models where those relationships are brokered at a community level and it has to be at that community level.

Mr Tanti—One of the things that we can trial now that we are involved in the MindMatters project is that the local Headspace centre works intensively with the schools in MindMatters, on

mind matters with students to make sure that those pathways are pretty concrete and that no-one is in any doubt as to what services are available in the community for young people.

Ms HALL—On this topic can I just throw something in because I am interested to hear your view. It could be argued that in schools there is a support service throughout the nation and that is the school chaplaincy scheme. Would you like to comment on that?

Miss Baldwin—I was just about to mention that a school chaplain would just concentrate on religion and not really ask what the problem was. They would just put their view on religion but not actually go to the real issue.

CHAIR—Could you give us an example?

Miss Baldwin—They would just say, ‘Why don’t you try to talk to God?’

CHAIR—And that is happening in schools that you are aware of?

Miss Baldwin—I went to a Christian school and they did pursue that angle. You need more of an open-minded person to talk to.

Dr Graetz—It is fair to say that there has been a great deal of caution within education with the school chaplaincy. I think they, like any professional, do vary considerably in their background in what they bring to bear with mental health in schools. Certainly, there has been some proselytising that we are aware of. Again, it is very much on an individual basis—schools will clearly use them when there are no other resources available, but I do not believe that anyone thinks that it has been a perfect solution.

Dr Selway—There may need to be training for chaplains around these issues so that they become more aware of what is available to support young people.

Mr Tanti—I think you are always going to have the religious overlay and there is always going to be a problem with the perception—certainly that is what we hear from young people—that it is not an unsafe space but not necessarily a completely safe space for them.

Dr Mathews—I would like to add that it is a problem if it replaces the health practitioner and evidence based interventions.

Ms Blanchard—Yes.

Ms RISHWORTH—In the schools and the services is there much work being done with carers? We have talked a lot about interventions but I think, particularly in schools, the school counsellor is focused on the person and often will say that they do not have time to then work with the families and carers. I would be interested to hear the perspective of Headspace and some of the other services. Someone mentioned this morning not having an item number to see parents when you are dealing with some of the mental health issues that underlie suicide.

Mr Tanti—I think there are a number of things that make those interactions complex. Even though we strive towards ensuring that carers and, in some instances, friends are engaged in the

discussion—I think Orygen was a pioneer in this sort of work; I did quite a lot of work there when I was involved with Orygen—obviously the young person needs to be comfortable with that, and sometimes there are complications around confidentiality. The clinician's job is to ensure that everyone gets through that space and, where possible, there is a dialogue that occurs with the family.

Certainly the MBS does not make it easy when you are in private practice, you work to a time line and it is about making an income. It does complicate the space, which is why we made the argument this morning about salaried positions being really critical in order to pick up that sort of work. There was a family worker at the Headspace centre but he actually worked privately and, while he was experienced in doing family counselling and family work, that is a bit more complex when you are running a private-public model. So salaried positions in that space are critical.

Dr Graetz—Going back even before then, in a lot of the work in primary schools and even in high schools you start with the parent-teacher interview where a classroom teacher might raise some concerns. Generally, preservice training in Australia does not actually have anything about how you actually engage and have conversations with parents. It is a highly skilled role that teachers are expected to take. A lot of the discussions on mental health do not start at the school counsellor. A lot of the conversations actually start at the level of the classroom teacher. One of the things we try to do under the KidsMatter model is provide training for teachers on how to talk to parents—that is, to understand that they have strong interests and to understand what they are going to want out of a conversation.

Prof. Milroy—Just in terms of the Indigenous perspective: sometimes there are very complex kinship networks and it is hard to know who you are meant to talk to and who has the decision-making or discipline role within the family. It can actually be quite a difficult system to negotiate as either a primary healthcare worker or even someone in mental health services. Certainly, most family therapy models do not take into account kinship networks and so they are not necessarily seen as appropriate.

Ms Blanchard—One of the groups of carers that are often left behind in this discussion are young people who take on caring responsibilities for a parent or another family member who might have a mental health difficulty, a drug or alcohol problem et cetera. The other group is young people who are partners of other young people who might have a mental health problem. We have found, working with Carers Australia in this space, that technology has provided a really interesting setting for those young people to seek help and support from others. Last week we ran an online forum facilitated by workers from Carers Australia. The young people came online and actually started some of those conversations and they highlighted some of the challenges but also some of the positive experiences they have had as a result of caring.

Dr Watson—We think the involvement of carers' families is really important. Wherever you have less resources you make that much harder. It is the thing that falls off the back of the truck, not because that is what people want to do. In terms of suicide, when one reviews those after the event, one of the common published problems that occurs is people did not listen or take enough notice to what families and carers had to say. So, if you set up these systems where that is harder, you end up with the recurring theme. Part of why we are here today is to try and end that recurrence. The Medicare schedule discourages that, so psychiatrists get lower Medicare rebates

if they are talking with families than if they are talking with the identified patient. The Commonwealth has used the Medicare schedule to drive change in the past. That would be an interesting one that we would be happy to work with.

The last thing is that a lot of youth with suicidal thinking actually need decent assessment. Part of decent assessment is speaking with families, carers and others. Part of what is easy to miss around some of this is that complex cases do not always present initially as complex cases. We have talked today about some areas where you will find complex cases, but in general practice or in primary care or in schools there are complex cases that do not necessarily look complex on day 1. Involving families is one way of teasing out that complexity. That is a really important point you have made.

Dr Mathews—I support what Daryl was saying. I agree. The MBS items really make it prohibitive. In fact, psychologists do not get any rebates for working with families, so it is almost impossible to involve a family in working with the young person.

Ms HALL—The question that I would like to ask goes back to what Dr Watson was saying in the beginning. I think it has been brought out in different ways through the discussion that we have had. Firstly, you mentioned post discharge and then there was some talk about specific initiatives and programs and collaborative care. They are the first three points I wrote down. Maybe it was brought up by different people, but I know that Dr Watson started with the post-discharge programs. My question relates to how we link all those together. How, with the post-discharge program, we can ensure that there is the 12-month monitoring—that is what I wrote down—and what the government needs to do to bring that about. There is a need to bring all the parties together. It has been brought up so many times.

Dr Mathews—I might have talked a little bit about that. I was suggesting that a case management type model is something that might work so that there is one person who is linked in with the young person who can coordinate some of the other services so that there is cooperation. That is one model that could be trialled.

Ms HALL—I agree. I think a case management model is a good way to go, but who has ultimate responsibility? That is the question.

Dr Watson—I think your question leads us down to some clinical jargon which I will say up front so that I can dump after that. What you are really looking at is: how can we generate integrated models and how can we collaborate better around these things?

Ms HALL—Absolutely.

Dr Watson—Again, if you have pressure in the system, that is where you lose people. They are in a high-risk group that is easy to identify and there are programs that work for those groups. If we look at the suicide attempters, in our submission we have referenced programs that actually work on the ground around that, but most places do not have them and that presents a real problem.

One way that you can claw some money back around that is what we were talking about before: can we prevent people getting to the post-discharge treatment and pick them up without

big hospital care, which is really quite expensive? Part of the inefficiency that we have in the community mental health sector now is that as soon as it is full you spill over into more expensive care, which then makes it less likely that you are ever going to have space again in the future. But those programs are relatively easy to roll out, relatively cheap and, from the evaluation research I have seen, seem to be perfectly effective. That is what we need to do.

Ms HALL—The other question went to social networking and using technology as a tool. How do we best do this? You have referred to it quite a few times this afternoon. How can that best be utilised by the government to turn this around? I agree that young people are nearly obsessed with social networking. Their lives revolve around it. To me it appears to be a really wonderful tool.

Miss Baldwin—The amount of attention young people try to get from other people—off Facebook, for example, with the statuses they put up—suggests they are trying to gain attention. Who is at home with them? They are obviously not getting attention, so they are trying to get it off other people. I do not know whether that goes towards your general thing.

Ms Blanchard—There is enormous potential to use information communication technology. We know that 95 per cent of young people regularly use the internet and even more use a mobile phone, so when I am talking about information communication technology I am not just talking about web based services but also about the potential of mobile applications and serious gaming to improve mental health and wellbeing. There are a number of groups who do not have as prolific an access to technology. They include Indigenous communities and people with disabilities. They are two groups that have been identified as having reduced access.

I draw your attention to *E-mental health: a 2020 vision and strategy for Australia*, which was authored by Professor Helen Christensen from the Centre for Mental Health Research at ANU, Judy Proudfoot from the Black Dog Institute, Gavin Andrews from the University of New South Wales, Britt Klein from Swinburne University, David Kavanagh from QUT, Dawn O'Neil and Alan Woodward from Lifeline, Leonie Young from beyondblue and Kerry Graham from the Inspire Foundation. In that document the authors set out an integrated model called an e-health platform that would bring together a number of the different e-mental health services that operate in Australia to provide relevant information and applications, including things like online counselling, serious gaming and social media applications, and provide appropriate connection and integration with face-to-face services like Headspace and Orygen. The idea would be that this particular platform would be something that young people and, indeed, mental health consumers and carers across all populations could go to to find the very best evidence based information resources and applications.

One of the things that I really caution against, though, is developing yet another website for young people to go to. One of the things that we have in Australia is a proliferation of e-health resources, and it is really important that we leverage the resources of all of the organisations that are around to provide young people with the most relevant information at the time that they need it. The Inspire Foundation is at the moment taking the lead in bringing together 50 organisations across the NGO, government, corporate and academic sectors. In terms of corporate partners, we have Google on board to support us in establishing a research facility for young people, technology and wellbeing. We hope that bringing together all of these partners and supporting initiatives like the national e-health platform will create an opportunity to leverage the resources

that are already out there. We invite government to work with us in establishing that research facility and supporting the e-health platform.

Ms HALL—Can Facebook and Twitter be used as well?

Ms Blanchard—Absolutely. So when I talk about social media applications—for example, our reachout.com website, which has a 56 per cent awareness rate amongst young people—one of the challenges is actually getting young people to that website.

Ms HALL—That is right.

Ms Blanchard—But we know that, on a day-to-day basis, young people are using Facebook and Twitter. So we maintain a presence within those social networking environments, as do the organisations like Headspace, Sane Australia, et cetera. And there is an opportunity to pull content and applications of the ReachOut website of the Headspace website or youth beyondblue and deliver them to young people within that social networking space that they are already in. So it complements what is happening on all of these other sites—it is part of an integrated solution.

Mr Tanti—One of the difficulties in this space, as was just alluded to, is that we are duplicating or recreating online the complexity that currently exists in the community. Headspace has also put a proposal to government to augment our face-to-face services, the idea being that e-services are terrific and a great entry point but sort of one-dimensional. There needs to be something backing that up and generally that is face-to-face counselling. New Zealand run a website called The Lowdown, which is a really terrific website that actually engages a range of sports people and celebrities in providing very clear mental health messages to young people. But the website also provides the opportunity to receive online counselling and case management online. So there is a rather sophisticated backroom operation around monitoring a young person and where they are at, keeping file notes et cetera. It is a very good service. We approached the Department of Health and Ageing to run a similar website in Australia that would back up the existing Headspace sites. I think it is an obvious solution. We need to do something in the e-space and we need to bring it all together, because it is incredibly loose. We know that young people use the internet. We know they use social networking. We need to provide something there.

CHAIR—I have a question specifically about the national suicide prevention strategy. If we were to measure it—I know it has morphed a couple of times since it was first announced—has it been effective? If not, why not? What improvements could be made to it?

Ms Robinson—I think that is a really important question. The answer is that we do not know whether or not it has been effective. This is for a couple of reasons. We were involved in doing some evaluation of the previous incarnation of the life strategy. There were two reasons why we do not know whether or not it has been effective. One is that the data collection mechanisms for key high-risk groups who are identified under the strategy as priority groups had no data collection around whether or not they had committed suicide. For example, groups that we have talked about such as people with mental health problems, people who had previously engaged in self-harm and various other groups had no mechanisms for recording whether those people had died by suicide or what the rates of suicide were in those groups, so it was very hard to know whether the strategy was correctly targeting those groups.

The other reason is that the activity that occurred underneath the strategy was not evaluated properly. We were brought in as part of a consortium of Melbourne University and various other institutions. We were asked to evaluate the strategy as a whole, and as part of that activity we looked at all the different individual evaluations that were supposed to have been done on the individual activities. The strategy funded a 156 smallish, pilot-type projects that were designed to target the at-risk groups that the strategy had identified. We were brought in to look at their evaluations to determine whether or not the funded activity had been effective. We found that there were very few of those things that were evaluated properly. Most of the evaluations that occurred were retrospective and opinion seeking: 'Do you think this has been effective?' 'Has it done what it's supposed to have done?' People gave an opinion about that. There was very little pretest and post-test.

CHAIR—As part of the national strategy there should have been evaluations done, but you are saying they were never done.

Ms Robinson—They were not done.

CHAIR—That is good to know.

Ms Robinson—The strategy certainly paid lip service to the idea that evaluation needed to take place. They said they were going to fund a series of projects and that they expected them to be evaluated, but they were not evaluated—and whether they were resourced adequately in order to evaluate themselves properly is another question as well. Many of the groups who were running small projects would not have been in a position to conduct rigorous evaluation. They would have needed support to be able to do that and that support was not systematically provided. So the evaluations that were done were piecemeal, they were underfunded and they were not rigorous in research terms by any means—there were no control groups, comparison groups and those sorts of things. So whilst a lot of money was spent under the strategy—we welcome that; we want money to be spent in this field—we came away with very little idea as to whether the strategy or any activities that were part of it had been effective or not.

Dr Graetz—A lot of the evaluation in Australia happens retrospectively and is ad hoc to program development. It is always a very wise to consider an evaluation program from the start because doing it halfway through or at the end is very problematic. Also, having the evaluation teams engaged at the start would better frame the strategy itself because it pins them down to say: 'How can this be evaluated? How do we know this is working, or not working?' I think you get a better strategy and a better approach. But you need to have it upfront as a starting point and commit some funds to evaluate it, or even get an evaluation model you can run with and provide options. I think it reflects what happens with evaluation generally in a lot of areas.

Dr Matthews—Hopefully some of that will change. The Australian Psychological Society was funded by Crisis Support Services, who oversee the life resources to develop workshops around evaluating suicide prevention programs. We have been rolling those programs out as we speak. They are full-day workshops on evaluation both before and after. We encourage them to implement that when they are designing their programs. We also encourage them to involve universities and other organisations where possible. So hopefully we will see some better data coming out of the programs that are being run.

Prof. Milroy—In terms of evaluating some of this stuff, you do not really see the results until years down the track. So it depends what you think you are going to gain out of the evaluation first up—because some things are going to be measured very late.

Dr Watson—The college agrees with the view that has been put on your question today. We also think it should continue. Sometimes when you are developing these areas you need to have things rolled out and funded and uncover what some of the problems are. So here is a more structured way of evaluating what happens. Picking up the points that Professor Milroy has made would be a worthwhile thing. It may have been quite a useful thing to go through this process to get where we are, and because there have been problems does not mean we should not continue with that strategy, it just means we need to learn from that and look at doing it better.

CHAIR—Does anybody have anything they would like to add before we close off?

Dr Selway—I often ponder why it is that in our society our youth are suffering so much. Often we look to governments and agencies and groups, but very seldom do we look to individuals to take responsibility for care, love and compassion towards the young people around us.

Miss Baldwin—I think adults need to have confidence that young people can deliver a message to other young people.

Ms HALL—So there should be more emphasis on a peer support approach as one strategy?

Miss Baldwin—Yes.

CHAIR—Thank you very much for your statements and your answers to our questions; they will be very valuable when we draft our recommendations. If there is anything else you wish to feed through to us, feel free to do so through the secretariat. That will form part of our evidence when we come up with our recommendations. I thank everyone for attending today and for your very informative contributions. I thank the committee for coming to Melbourne, I thank the secretariat for their assistance and I thank Hansard, who vigorously and tirelessly recorded every single word that was said—and this will appear in the *Hansard* in the next couple of weeks.

Resolved (on motion by **Ms Rishworth**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 4.06 pm